| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/02/2026 |
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| NAME OF PROVIDER OR SUPPLIER St Crispin Living Community | | STREET ADDRESS, CITY, STATE, ZIP CODE 213 Pioneer Road Red Wing, MN 55066 | |

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

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interview and document review, the facility failed to report an allegation of neglect to the State Agency (SA) within the required timeframe for 1 of 3 resident (R1) reviewed for pharmacy services.Findings include:R1's physician orders dated 11/28/23, identified an order for Morphine immediate release (IR) 15 milligrams (mg) tablet to be administered four times daily for chronic pain syndrome at 6:30 a.m., 11:30 a.m., 4:00 p.m., and 8:00 p.m. An additional order dated 11/14/22, identified Morphine (IR) 7.5 mg twice daily as needed for pain.R1's February 2026, medication administration record (MAR) identified the following missed doses of scheduled morphine due to the medication not being available in the facility:-On 2/2/26, the scheduled 4:00 p.m. and 8:00 p.m. doses of morphine (IR) 15 mg were documented as Not Administered. On 2/3/26, the 6:30 a.m. scheduled dose was documented as Not Administered, and the 11:30 a.m. dose was administered late at 1:36 p.m.R1's progress notes dated 2/2/26 at 7:49 p.m., identified staff contacted the on-call provider and pharmacy multiple times regarding the morphine prescription and documented the medication was not available for administration. At 10:05 p.m., identified that nurse practioner (NP)-A stated she had sent R1's prescription for morphine to the pharmacy at 7:00 p.m.; however, the pharmacy had not received or located the prescription despite multiple follow-up calls. NP-A stated she would not fax the prescription to the facility that evening but may do so the following morning. At 10:20 a.m., identified that staff spoke with triage registered nurse on-call (TRNO)-A regarding the unavailable 6:30 a.m. - 8:30 a.m., morphine dose. TRNO-A stated she sent a renewed order to the pharmacy and contacted the on-call certified physician assistant (CPA-A) in case the prescription needed to be sent again.R1's progress note dated 2/3/26 at 10:20 a.m., identified that staff spoke with triage registered nurse on-call (TRNO)-A regarding the unavailable 6:30 a.m. - 8:30 a.m., morphine dose. TRNO-A stated she sent a renewed order to the pharmacy and contacted the on-call certified physician assistant (CPA)-A in case the prescription needed to be sent again.During an interview on 2/24/26 at 3:13 p.m., the director of nursing (DON) stated she was not aware that R1 had missed multiple scheduled doses of morphine on 2/2/26 and 2/3/26 due to the medication not being available. The DON confirmed the event constituted an allegation of neglect and had not been reported to the State Agency.Facility policy titled Abuse Prevention Plan, revised 8/14/20, identified all forms of abuse, neglect, misappropriation of resident property, and financial exploitation of residents by facility staff are strictly prohibited. The policy defined neglect as the failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy further identified that any person with knowledge or suspicion of abuse, neglect, misappropriation of resident property, or financial exploitation must report the concern immediately to the charge nurse or supervisor, who will notify the Executive Director or designee. The policy indicated that the facility is responsible for reporting suspected abuse or neglect in accordance with legal requirements. If the event involves abuse or results in serious bodily injury, the suspicion must be reported immediately but not later than two hours after forming the suspicion. If the event does not involve serious bodily injury, the suspicion must be reported no later than 24 hours after forming the suspicion. The policy further identified that for Minnesota facilities, suspected abuse or<br>(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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| St Crispin Living Community | 213 Pioneer Road<br>Red Wing, MN 55066 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | neglect must be reported to the Minnesota Department of Health (MDH) via the online reporting system immediately upon receiving the report. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure scheduled pain medication was re-ordered and available per physician orders for 1 of 3 residents (R1) reviewed for pain management. Findings include: R1's face sheet, printed 2/24/26, identified diagnoses including chronic pain syndrome (long-term, ongoing pain that is difficult to manage); acquired absence of the left leg above the knee (loss of the left leg due to prior injury); left hand post-traumatic osteoarthritis with contracture (arthritis, stiffness, and limited movement of the left hand resulting from a prior shrapnel injury caused by a landmine explosion); and post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing a traumatic event). R1's annual Minimum Data Set (MDS), dated [DATE], indicated his cognition was intact. He was dependent on staff for transfers and toileting and utilized a motorized scooter for mobility. The MDS further identified that R1 was on a scheduled pain management regimen and did not receive PRN (as needed) pain medications or non-pharmacological pain interventions. During the pain assessment interview, R1 reported experiencing frequent pain of moderate intensity over the past five days, which occasionally limited his daily activities. The MDS also documented that during the previous seven days, R1 received high-risk medications including antianxiety, antidepressant, and opioid medications. R1's care area assessment (CAA) dated 2/2/26, identified Section 19, Pain, noting that R1 complained of frequent, moderate pain over the last five days and had not used PRN pain medication during that period. The CAA indicated that nursing staff would continue to assess R1's pain each shift, notify the provider of any unrelieved pain, and utilize both pharmacological and non-pharmacological interventions to maintain effective pain management. R1's care plan dated 5/8/19, identified a problem related to pain/discomfort; however, the problem statement was left blank, and no baseline pain level was documented. The corresponding approach, also dated 5/8/19, included interventions when pain is expressed, such as offering heat, repositioning, analgesics, and mindful relaxation techniques. An additional approach dated 1/5/22, required completion of a pain scale every shift. Review of R1's care plan lacked clear guidance for documenting baseline pain and did not provide comprehensive direction for managing chronic pain, scheduled opioid administration, or monitoring for severe pain when medications were unavailable. R1's physician orders dated 11/28/23, identified an order for morphine immediate release (IR) 15 milligram (mg) tablet to be administered four times daily for chronic pain syndrome at 6:30 a.m., 11:30 a.m., 4:00 p.m., and 8:00 p.m. An additional order dated 11/14/22, identified to administer morphine (IR) 7.5 mg twice daily as needed for pain. R1's February 2026, medication administration record (MAR) identified the following missed doses of scheduled morphine due to the medication not being available in the facility: -On 2/2/26 the scheduled 4:00 p.m. and 8:00 p.m., doses of morphine (IR) 15 mg were documented as Not Administered. -On 2/2/26 at 5:03 p.m., PRN morphine 7.5 mg tab was given, as regular dose was not available. -On 2/3/26 the 6:30 a.m., scheduled dose was documented as Not Administered, and the 11:30 a.m. dose was administered late at 1:36 p.m. R1's progress notes dated 2/2/26 at 7:49 p.m., identified staff contacted the on-call provider and pharmacy multiple times regarding the morphine prescription and documented the medication was not available for administration. At 10:05 p.m., identified that nurse practitioner (NP)-A stated she had sent R1's prescription for morphine to the pharmacy at 7:00 p.m.; however, the pharmacy had not received or located the prescription despite multiple follow-up calls. NP-A stated she would not fax the prescription to the facility that evening but may do so the following morning. R1's progress note dated 2/3/26 at 10:20 a.m., identified that staff spoke with triage registered nurse on-call (TRNO)-A regarding the unavailable 6:30 a.m. - 8:30 a.m., morphine dose. TRNO-A stated she sent a renewed order to the pharmacy and contacted the on-call certified physician assistant (CPA)-A in case the prescription needed to be sent again. R1's Vitals Report dated 2/2/26 through 2/3/26ˆidentifiedˆno food intake documented for either day. On 2/4/26, intake documentation<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | reflected improved oral intake. Resident and family interviews alsoˆindicatedˆdecreased appetite during the medication gap.ˆ In review of R1's record between 2/2/26 and 2/3/26 there was no indication of completed comprehensive pain assessments completed that would include pain characteristics. In addition, the record did not include documentation of non-pharmacological interventions attempted or offered, no indication of increased monitoring for escalating pain symptoms and opioid withdraw symptoms and no offer or suggestion for emergency transfer to the hospital for pain management. During an observation and interview on 2/24/26 at 9:28 a.m., R1 was dressed in pajamas and seated in his wheelchair in front of a card table in his room, watching the news on the television mounted on the wall in front of the table. He was noted to have an above-the-knee amputation on his left leg. R1 indicated he was a Navy war medic from the Vietnam War era and that his left lower leg was blown off when he stepped on a landmine over 57 years ago. He stated that he sustained several pieces of shrapnel to his left leg, groin, and both arms, which could not be surgically removed and continue to cause him significant pain to this day. R1 reported he receives short-acting morphine four times a day. When he receives all scheduled doses, his pain was at his baseline, which he rated as 5 out of 10. R1 stated that on 2/2/26, he ran out of morphine in the afternoon and did not receive it again until the following afternoon, leaving him without his scheduled doses for almost a full day. During this time, he reported his pain was a 10 out of 10, he was unable to get out of bed, and his appetite was decreased. He further stated that his anxiety worsened, making it difficult to swallow because it felt like his throat was closing. R1 reported that family member (FM)-A, his advocate, becomes upset when he does not advocate for himself because she does not want to see him in pain. He stated part of the reason he does not ask for morphine when in significant pain was that he just shuts down and does not want to bother anyone. R1 identified his biggest complaint at the facility was not having his pain medication available when he needed it. During a follow-up interview on 2/26/26 at 8:50 a.m., R1 stated that he does not like to complain about pain and tends to zone out when experiencing it. R1 did not recall waking up during the night due to pain. The following morning, he reported severe pain that prevented him from getting out of bed. He described the pain as being concentrated in his left leg and right hands, feeling as if they were being stabbed with a million knives and also affecting the back of his left leg and his groin. R1 stated that when his pain reaches that intensity, he shuts down and is unable to think clearly. He did not remember eating that day, explaining that extreme pain makes it impossible for him to function. R1 further stated that facility staff do not ask for specifics about his pain and only request a numerical rating, which he finds unhelpful and difficult for accurately describing the severity of his pain. During an interview on 2/24/26 at 10:30 a.m., FM-A stated that R1 was her husband, and they had been married for 48 years. FM-A reported that because of the shrapnel in his groin, R1 had experienced severe pain when he was at home, particularly at night, which sometimes required him to sit in a tub of hot water to help ease the pain. She further stated that he has numerous pieces of shrapnel in his left arm and left leg. FM-A described the events of 2/2/26 and 2/3/26, when the facility ran out of his morphine, stating that R1 was in so much pain he even reported that his hands hurt. She noted that when R1 experienced severe pain, he loses his appetite and was unable to eat much. On that day, he was lying in bed, and the pain was particularly intense in the back of his upper left leg, running upward through the back. FM-A stated that she encouraged R1 to ask for the liquid morphine, but he reported that it was unavailable as well. She added that the entire incident exacerbated his anxiety. FM-A reported that she visits R1 every day after lunch and spends a few hours with him. She also stated that R1 calls her every evening after supper to talk before going to bed. During a follow-up interview on 2/26/26 at 8:58 a.m., FM-A stated that she arrived around 12:00 p.m. to 12:30 p.m., on 2/3/26. She reported that R1 was very stoic about his pain and becomes very quiet when experiencing it. When she arrived, he was in bed, and she knew he was in pain because he was not talking much. She observed that he was sweating and that the back of his pajamas were wet. FM-A asked the nurse where the liquid morphine backup was, and the nurse stated it was not available. She<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | noted that she did not stay long because R1 had his eyes closed, did not want to talk, and was in too much pain. Before she left, she observed R1 attempting to use the TV remote. He was unable to operate it correctly, which was unusual for him, and they were unable to watch the Westminster Kennel Club dog show as they had planned. FM-A stated that he was confused, in too much pain, and needed to rest. She found this very upsetting, knowing he was suffering and that there was nothing she could do to help. FM-A also noted that R1 did not call her that night, which was unusual because he normally calls her after supper. During an interview on 3/2/26 at 10:05 a.m., registered nurse (RN)-C stated he worked the day shift on 2/2/26 on R1's unit. RN-C reported that during his shift he identified R1 would not have a sufficient supply of his scheduled morphine IR 15 mg tablets to continue as ordered. RN-C stated he did not contact the provider to obtain a new prescription before the end of his shift due to time constraints. RN-C described R1 as very stoic, stating that staff must often prod him to report or describe his pain. During a phone interview on 2/25/26 at 11:10 a.m., RN-A stated she was the charge nurse on 2/2/26 for the evening shift on R1's unit. RN-A confirmed she did not have scheduled dose of morphine to give at 4:00 p.m., or 8:00 p.m., so she administered the 7.5 mg PRN dose around 5:03 p.m. RN-A observed that by 8:30 p.m., R1 appeared uncomfortable, quiet, making small facial grimaces and showing subtle signs of pain. RN-A described R1 as very stoic, stating that staff must often prod him to report or describe his pain. RN-A indicated missing doses of scheduled morphine put R1 at risk of significant unmanaged pain. During a phone interview on 2/25/26 at 11:42 a.m., RN-B stated she worked the day shift on 2/3/26 on R1's unit. RN-B confirmed R1 had missed 4 full doses of his scheduled morphine. RN-B stated that when she entered R1's room to administer his morning medications, he asked if his morphine was available and indicated it had been out, remarking that it felt like a week to him. She documented R1's pain at a level 7 out of 10, noting it was significant for him and that he did not get out of bed during the shift due to pain. RN-B described R1 as very stoic, stating that staff must often prod him to report or describe his pain. RN-B stated by the time she got the actual morphine it was not given until 1:37 p.m., when she documented it. During an interview on 2/24/26 at 3:13 p.m., director of nursing (DON) stated she was not aware that R1 missed four doses of morphine-on 2/2/26 at 4:00 p.m. and 8:00 p.m., and on 2/3/26 at 6:30 a.m., and 11:30 a.m., resulting in several hours without his pain medication. She acknowledged that this could place R1 at risk for acute opioid withdrawal and significant pain, representing a significant medication error. The DON noted that it did not appear the provider had been notified about the missed doses and that no orders were in place during this time to control his pain. She also indicated she was unsure whether R1 was comprehensively assessed for pain or withdrawal symptoms during the missed doses but noted that missing a dose would typically trigger such assessments. During a follow-up interview on 2/25/26 at 8:39 a.m., the DON stated she reviewed R1's TAR and noted that on 2/3/26, his pain was documented at a level 7 out of 10 on the day shift. She further stated that she would have expected nursing staff to contact her if a narcotic dose for any resident was missing and confirmed that she was not notified when this occurred. The DON confirmed that R1's missed morphine doses were not monitored for withdrawal or alternative pain management during the time the medication was unavailable. The DON also confirmed that NP-A did not have any orders in place to comprehensively assess R1 for increased pain or opioid withdrawal symptoms due to the missed doses. During a phone interview on 2/26/26 at 11:04 a.m., pharmacist (P)-A was informed of the situation involving R1 was described to her to include his reports of pain and symptoms, P-A stated this would have been considered an emergent situation. Regarding Morphine IR, P-A stated it generally lasts approximately 4 to 5 hours before another dose is needed, and the patient would begin exhibiting signs and symptoms of pain. She stated that being 20 hours after the last 7.5 mg dose would be considered an emergent situation. She explained that missing doses for over 20 hours significantly increases the likelihood of severe pain and early opioid withdrawal symptoms, including sweating. P-A stated she would expect nursing staff to monitor for increased pain and signs and symptoms of withdrawal after the first missed dose. During a phone interview on 2/26/26 at 2:31 (continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | p.m., NP-A confirmed that she did not check to ensure the morphine prescription was sent to the pharmacy on 2/2/26, did not provide orders for alternate pain management, and did not instruct nurses to monitor for signs or symptoms of increased pain or withdrawal for R1. During a phone interview on 2/26/26 at 12:32 p.m., the medical director stated that even one missed scheduled dose of (IR) morphine could result in physiological changes by approximately 9:00 p.m., as R1 did not receive his full dose. The Medical Director stated that even one missed scheduled dose of (IR) morphine could result in physiological changes by approximately 9:00 p.m., as R1 did not receive his full dose. He emphasized that a missed dose should trigger nursing staff to assess and monitor escalating pain and signs and symptoms of acute opioid withdrawal. Regarding pharmacology, he explained that the half-life of (IR) morphine was approximately 3 to 4 hours. He stated that it generally takes 3 to 4 half-lives for a medication to be substantially eliminated from the system, which would be approximately 16 to 20 hours. He indicated that during this time, R1 would not be in his usual state and would theoretically experience pain worse than his baseline. He identified worsening physical pain, sweating, nausea, and vomiting as expected signs and symptoms when morphine is no longer present in the system. He further noted that pulse rate may not be a reliable indicator in this case because R1 was on blood pressure medications. He emphasized that the clinical team is responsible for ensuring appropriate communication, medication availability, and monitoring when a scheduled opioid dose is missed. Facility policy entitled, Pain Management, revised 09/07/23, identified that residents' pain should be evaluated, documented, and reassessed at regular intervals, with each new report of pain, and after pharmacological or non-pharmacological interventions. The policy emphasized an interdisciplinary approach, resident and responsible party involvement, and consideration of physical, emotional, social, spiritual, and financial domains of pain. Review of the policy does not specify when or where a comprehensive pain assessment must be completed, lacks guidance for documenting baseline pain, and does not outline steps to follow when scheduled pain medications are missed or unavailable, limiting its effectiveness in ensuring safe and timely pain management. |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>Based on interview and document review, the facility failed to ensure a nurse practitioner or physician provided timely orders to address a resident's immediate care needs when a scheduled prescribed narcotic pain medication was not available for administration for 1 of 3 residents (R1) reviewed for physician services. This had the potential to affect all residents residing in the facility.Findings include:R1's physician orders dated 11/28/23, identified an order for morphine immediate release (IR) 15 milligram (mg) tablet to be administered four times daily for chronic pain syndrome at 6:30 a.m., 11:30 a.m., 4:00 p.m., and 8:00 p.m.R1's February 2026, medication administration record (MAR) identified the following missed doses of scheduled morphine due to the medication not being available in the facility:-On 2/2/26 the scheduled 4:00 p.m. and 8:00 p.m., doses of morphine (IR) 15 mg were documented as Not Administered.-On 2/2/26 at 5:03 p.m., PRN morphine 7.5 mg tab was given, as regular dose was not available.-On 2/3/26 the 6:30 a.m., scheduled dose was documented as Not Administered, and the 11:30 a.m. dose was administered late at 1:36 p.m.R1's progress notes dated 2/2/26 at 7:49 p.m., identified staff contacted the on-call provider and pharmacy multiple times regarding the morphine prescription and documented the medication was not available for administration. At 10:05 p.m., identified that nurse practitioner (NP)-A stated she had sent R1's prescription for morphine to the pharmacy at 7:00 p.m.; however, the pharmacy had not received or located the prescription despite multiple follow-up calls. NP-A stated she would not fax the prescription to the facility that evening but may do so the following morning.R1's progress note dated 2/3/26 at 10:20 a.m., identified that staff spoke with triage registered nurse on-call (TRNO)-A regarding the unavailable 6:30 a.m. - 8:30 a.m., morphine dose. TRNO-A stated she sent a renewed order to the pharmacy and contacted the on-call certified physician assistant (CPA)-A in case the prescription needed to be sent again.During an observation and interview on 2/24/26 at 9:28 a.m., R1 stated that on 2/2/26, he ran out of morphine in the afternoon and did not receive it again until the following afternoon, leaving him without his scheduled doses for almost a full day. During this time, he reported his pain was a 10 out of 10, he was unable to get out of bed, and his appetite was decreased. He further stated that his anxiety worsened, making it difficult to swallow because it felt like his throat was closing.During a phone interview on 2/25/26 at 11:10 a.m., registered nurse (RN)-A stated she was the charge nurse on 2/2/26 for the evening shift on R1's unit. She was informed by the day shift nurse that R1 only had a single 7.5 mg PRN dose of morphine remaining. RN-A attempted to contact NP-A multiple times between 2:30 p.m. and 10:00 p.m. but only reached the triage nurse. RN-A administered the 7.5 mg PRN dose around 5:03 p.m. and observed that by 8:30 p.m., R1 appeared uncomfortable, quiet, making small facial grimaces and showing subtle signs of pain. RN-A also noted that the MAR reorder button could not be used because a new prescription was required. RN-A stated she finally reached NP-A via phone around 10:00 p.m. and asked if the morphine order had been sent. NP-A stated she had sent it at 7:00 p.m., but refused to resend it electronically that night, saying she would do it in the morning. NP-A did not offer any alternative pain management, did not give orders to monitor opioid withdrawal symptoms, or directions of what to do with increased pain. RN-A identified the root cause as the failure to obtain a new prescription in a timely manner, which put R1 at risk to experience significant unmanaged pain. She emphasized that timely medication ordering and monitoring for missed doses are critical to prevent resident harm.During a phone interview on 2/26/26 at 2:31 p.m., NP-A stated she was on-call provider on 2/2/26, and she received a call in the evening from a nurse at the facility regarding a refill for R1's morphine. She could not recall the exact time, but it was before bedtime. NP-A stated she had already reviewed the refills earlier that day and clicked sign on the order in Epic. She was not aware if the prescription reached the pharmacy and did not have time to verify. NP-A stated she was unaware and didn't think to ask if R1 had already missed a dose and did not know he did not have medication for that evening. She stated that she would not have instructed the nurses to assess R1 for increased pain or monitor for withdrawal symptoms over<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | a missed dose. NP-A further stated it was not typical to call the pharmacy to provide a verbal order for morphine and that, in their setting, they generally allow a day and a half for this type of medication delivery. She indicated that if a resident misses a dose or two, there is little the facility can do, as they are not in a hospital and must rely on the pharmacy's delivery schedule. NP-A reported she found out the next day that R1 never received the scheduled morphine prescription. She initially thought the inquiry was about a probiotic, not morphine. NP-A was asked if she recalled receiving an email from the DON inquiring about R1's morphine order on 2/3/26, and she had responded in the email stating she had heard or seen nothing about R1's morphine. NP-A stated she recalled the email but could not recall what her response was. NP-A further stated that when e-prescribing fails, she has no knowledge of a backup plan and that it was above her level of authority. She verified that she did not check to ensure the morphine prescription was sent to the pharmacy, did not provide orders for alternate pain management, and did not instruct nurses to monitor for signs or symptoms of increased pain or withdrawal for R1.During a phone interview on 2/26/26 at 11:04 a.m., pharmacist (P)-A stated the pharmacy did not receive a morphine prescription from NP-A on 2/2/26; the pharmacy received a prescription on 2/3/26 at 11:19 a.m., for 120 tablets of Morphine Immediate Release (IR)15 mg written by CPA-A. The prescription included authorization to obtain a dose from the emergency kit (e-kit) at 11:19 a.m. P-A explained that prescriptions are typically sent electronically. After hours, the pharmacy allows nurses to provide the provider's contact number so the pharmacy can obtain an emergency verbal prescription for controlled substances. She stated this process has been in place for the three years she has worked there and that the pharmacy maintains 24-hour staffed pharmacists. After the situation involving R1 was described to her to include his reports of pain and symptoms, P-A stated this would have been considered an emergent situation and the lack of medication would have constituted an omission medication error.During an interview on 2/24/26 at 3:13 p.m., the Director of Nursing (DON) confirmed staff contacted the on-call practitioner when the morphine was not available and verified the medication had not been obtained in time for R1's scheduled doses.During a phone interview on 2/26/26 at 12:32 p.m., the medical director stated that NP-A reported she had sent R1's morphine prescription on 2/2/26; however, the pharmacy did not receive it. MD-A explained that if NP-A had called to obtain an emergency supply, the missed doses could have been prevented, and he further stated that he could have authorized an emergency supply if contacted. He reported he was not notified of the situation at the time.Facility policy entitled, Physician Services, revised on 1/2019, identified requirements for physician supervision and oversight of residents, including that a physician, nurse practitioner, or physician assistant must provide orders for the resident's immediate care needs, all physician orders must be followed and documented, and residents must be seen by a physician at specified intervals. The policy outlined the delegation of tasks to nurse practitioners, physician assistants, dieticians, and therapists under the supervision of the attending physician, and required timely communication, documentation of verbal orders, and 24-hour availability of physician services in case of emergency. The policy emphasized that residents remain under physician care and that physician visits, whether personal or via delegated provider, review the resident's total program of care, including medications and treatments. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/02/2026 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| St Crispin Living Community | 213 Pioneer Road<br>Red Wing, MN 55066 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure effective pharmacy services for availability in opioid pain medication for 1 of 3 residents (R1) reviewed for pharmacy services. As a result of the facility's failures pain medications were not administered to R1 due to prolonged medication unavailability which caused escalating severe unmanaged pain that was more than transient and possible early opioid withdrawal symptoms without alternate treatment or monitoring. In addition, the facility failed to ensure proper reconciliation, transcription and accountability of controlled substance medications when staff did not accurately transcribe physician orders into the narcotic record, including the prescription number, medication name, dosage and complete order instructions. Narcotic records were incomplete and inconsistent with pharmacy delivery documentation, compromising the facility's ability to track, verify, and ensure availability of ordered controlled substances. The immediate jeopardy (IJ) began on 2/2/26 when the facility failed to ensure R1's prescribed morphine was available for administration, resulting in one scheduled dose being administered at a reduced amount and three additional scheduled doses not administered. As a result, R1 went approximately 24 hours and 7 minutes without receiving a full scheduled 15 mg dose of morphine and approximately 20 hours and 33 minutes with only a partial 7.5 mg PRN dose rather than his ordered scheduled regimen. During this period, R1 experienced severe unmanaged pain, increased anxiety, sweating, decreased activity, and reduced oral intake, placing him at immediate likelihood for additional serious consequences, including worsening uncontrolled pain and possible early opioid withdrawal. The regional director of clinical services (RDCS), administrator, director of nursing (DON), and clinical reimbursement manager were notified of the IJ on 2/26/26 at 5:04 p.m. The IJ was removed on 2/27/26; however, noncompliance remained at a lower scope and severity of D, indicating no actual harm with potential for more than minimal harm that was not widespread. Findings include R1's face sheet, printed 2/24/26, identified diagnoses including chronic pain syndrome (long-term, ongoing pain that is difficult to manage); acquired absence of the left leg above the knee (loss of the left leg due to prior injury); left hand post-traumatic osteoarthritis with contracture (arthritis, stiffness, and limited movement of the left hand resulting from a prior shrapnel injury caused by a landmine explosion); and post-traumatic stress disorder (PTSD) (a mental health condition triggered by experiencing a traumatic event). R1's annual Minimum Data Set (MDS), dated [DATE], indicated his cognition was intact. He was dependent on staff for transfers and toileting and utilized a motorized scooter for mobility. The MDS further identified that R1 was on a scheduled pain management regimen and did not receive PRN pain medications or non-pharmacological pain interventions. During the pain assessment interview, R1 reported experiencing frequent pain of moderate intensity over the past five days, which occasionally limited his daily activities. The MDS also documented that during the previous seven days, R1 received high-risk medications including antianxiety, antidepressant, and opioid medications. R1's care plan dated 5/8/19, identified a problem related to high-risk medications that place R1 at risk for adverse reactions, including opioids. The corresponding intervention dated 5/8/19 was to administer medications per MD (Medical Doctor) order and report indications of intolerance, which include sweating, chills, diarrhea, anxiety, and irritability. R1's MD orders dated 11/28/23, identified for R1 to receive Morphine immediate release (IR) 15 mg tablet four times a day for chronic pain syndrome at the following times: 6:30 a.m. - 8:30 a.m., 11:30 a.m. - 1:00 p.m., 4:00 p.m. - 5:00 p.m., and 8:00 p.m. - 10:00 p.m. An additional order dated 11/14/22, identified for R1 to receive morphine (IR) 7.5 mg twice a day PRN (as needed). Facility document, All Conversations: Med Refill, for R1 dated 2/2/26, identified at 3:26 p.m., note from triage registered nurse on-call (TRNO)-A to nurse practitioner (NP-A) indicated skilled nursing facility (SNF) nurse called and needs a refill oh [sic] morphine only has half dose left. SNF nurse call intake refill<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | needed. R1's medication administration record (MAR) dated 2/2/26, identified R1's 11:30 a.m. - 1:00 p.m. Morphine (IR) 15 mg dose was documented as given and charted late at 1:29 p.m. During an interview on 3/2/26 at 10:05 a.m., registered nurse (RN)-C stated he worked the day shift on 2/2/26 on R1's unit. RN-C reported that during his shift he identified R1 would not have a sufficient supply of his scheduled morphine IR 15 mg tablets to continue as ordered. RN-C stated he did not contact the provider to obtain a new prescription before the end of his shift due to time constraints. RN-C described R1 as very stoic, stating that staff must often prod him to report or describe his pain. He reported that he communicated the need for a new prescription to the oncoming charge nurse but did not verify that the prescription had been obtained prior to leaving his shift.R1's medication administration record (MAR) dated 2/2/26, identified R1's 4:00 p.m. - 5:00 p.m. Morphine (IR) 15 mg dose was documented as Not Administered due to the drug not being available. Pharmacy and on-call provider were contacted three times.R1's MAR dated 2/2/26, identified R1's PRN Morphine (IR) 7.5 mg dose was documented as given at 5:03 p.m. due to full scheduled dose not available, waiting for new prescription from on-call provider.R1's MAR dated 2/2/26, identified R1's 8:00 p.m. - 10:00 p.m. Morphine (IR) 15 mg dose was documented as Not Administered. R1's progress notes dated 2/2/26 at 7:49 p.m., identified R1 had only a single 7.5 mg half tab of morphine available for the evening shift. The on-call provider was contacted at 3:21 p.m. to send a morphine prescription. The PRN dose was given at the scheduled time since the full dose was not available. The on-call provider has been called three times, and the pharmacy has been contacted four times with no confirmation of the prescription. R1 had another scheduled dose due at 8:00 p.m. Staff will continue to follow up to ensure the prescription is completed. During a phone interview on 2/25/26 at 11:10 a.m., RN-A stated she was the charge nurse on 2/2/26 for the evening shift on R1's unit. She was informed by the day shift nurse that R1 only had a single 7.5 mg PRN dose of morphine remaining. RN-A attempted to contact NP-A multiple times between 2:30 p.m. and 10:00 p.m. but only reached the triage nurse. RN-A administered the 7.5 mg PRN dose around 5:03 p.m. and observed that by 8:30 p.m., R1 appeared uncomfortable, quiet, making small facial grimaces and showing subtle signs of pain. RN-A described R1 as very stoic, stating that staff must often prod him to report or describe his pain. RN-A also noted that the MAR reorder button could not be used because a new prescription was required. RN-A stated she finally reached NP-A via phone around 10:00 p.m. and asked if the morphine order had been sent. NP-A stated she had sent it at 7:00 p.m., but refused to resend it electronically that night, saying she would do it in the morning. NP-A did not offer any alternative pain management, did not give orders to monitor opioid withdrawal symptoms, or directions of what to do with increased pain. RN-A identified the root cause as the failure to obtain a new prescription in a timely manner, which put R1 at risk to experience significant unmanaged pain. She emphasized that timely medication ordering and monitoring for missed doses are critical to prevent resident harm. R1's progress notes dated 2/2/26 at 10:05 p.m., contacted NP-A, who stated she sent R1's prescription for morphine to the pharmacy at 7:00 p.m. The pharmacy had been called three times after this and had not received or been able to locate the prescription. NP-A stated she would not fax the prescription to the facility tonight but may do so in the morning. During a phone interview on 2/26/26 at 2:31 p.m., NP-A stated she was on-call provider on 2/2/26, and she received a call in the evening from a nurse at the facility regarding a refill for R1's morphine. She could not recall the exact time, but it was before bedtime. NP-A stated she had already reviewed the refills earlier that day and clicked sign on the order in Epic. She was not aware if the prescription reached the pharmacy and did not have time to verify. NP-A stated she was unaware and didn't think to ask if R1 had already missed a dose and did not know he did not have medication for that evening. She stated that she would not have instructed the nurses to assess R1 for increased pain or monitor for withdrawal symptoms over a missed dose. NP-A further stated it was not typical to call the pharmacy to provide a verbal order for morphine and that, in their setting, they generally allow a day and a half for this type of medication delivery. She indicated that if a resident misses a dose or two, there is little the facility can do, as they are not in a hospital and must (continued on next page) |

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | rely on the pharmacy's delivery schedule. NP-A reported she found out the next day that R1 never received the scheduled morphine prescription. She initially thought the inquiry was about a probiotic, not morphine. NP-A was asked if she recalled receiving an email from the DON inquiring about R1's morphine order on 2/3/26, and she had responded in the email stating she had heard or seen nothing about R1's morphine. NP-A stated she recalled the email but could not recall what her response was. NP-A further stated that when e-prescribing fails, she has no knowledge of a backup plan and that it was above her level of authority. She verified that she did not check to ensure the morphine prescription was sent to the pharmacy, did not provide orders for alternate pain management, and did not instruct nurses to monitor for signs or symptoms of increased pain or withdrawal for R1. R1's MAR dated 2/3/26, identified R1's 6:30 a.m. - 8:30 a.m. Morphine (IR) 15 mg dose was documented as Not Administered. R1's progress notes dated 2/3/26, at 10:20 a.m., spoke with TRNO-A regarding the unavailable 6:30 a.m. - 8:30 a.m. Morphine 15 mg QID (four times a day) dose. TRNO-A stated she sent a renewed order to AlixaRx pharmacy at that time and also contacted the on-call provider, certified physician assistant (CPA)-A, in case the prescription needed to be sent again. Email correspondence: On 2/3/26 at 9:51 a.m., the DON sent a message stating: We called for a morphine prescription for R1. AlixaRx says they still do not have it, but I see a note you sent to Alixa last night, NP-A? Can we have assistance with this? Thanks. Facility document, All Conversations: Med Refill, for R1 dated 2/3/26, identified at 10:16 a.m., note from TRNO-A to CP-A identified, can we get this signed and sent, none left, also need order to take AM dose from the E-kit. At 10:19 a.m., PA-C then routed this conversation to TRNO-A. At 11:22 a.m., TRNO-A sent message to CPA-A, thank you for ordering medication, they also need an order for AM dose that stated it's ok to hold it. R1's progress notes dated 2/3/26, at 10:20 a.m., spoke with TRNO-A regarding the unavailable 6:30 a.m. - 8:30 a.m. Morphine 15 mg QID (four times a day) dose. TRNO-A stated she sent a renewed order to AlixaRx pharmacy at that time and also contacted the on-call provider, certified physician assistant (CPA)-A, in case the prescription needed to be sent againFacility document, All Conversations: Med Refill, for R1 dated 2/3/26, identified at 11:22 a.m., TRNO-A sent message to CPA-A, thank you for ordering medication, they also need an order for AM dose that stated it's ok to hold it.Return Email correspondence to the DON on 2/3/26 At 11:53 a.m., NP-A replied: R1's message was for his probiotic. I sent in the probiotic yesterday. I did not see or hear of anything regarding R1's morphine. R1's MAR dated 2/3/26, identified R1's 11:30 a.m. - 1:00 p.m. Morphine (IR) 15 mg dose was documented as Late Administration and given at 1:36 p.m. R1's treatment administration record (TAR) dated 2/3/26, documented a pain intensity rating of moderate, 7 out of 10 on the day shift. Review of R1's medication orders and February 2026 MAR and TAR identified that R1's last full scheduled dose of Morphine IR 15 mg before the medication gap was administered on 2/2/26 at 1:29 p.m. The next scheduled 4:00 p.m. dose on 2/2/26 was not administered due to the medication being unavailable. R1 then received only a partial PRN dose of Morphine IR 7.5 mg at 5:03 p.m. on 2/2/26 because the full scheduled dose was not available. The 8:00 p.m. scheduled dose on 2/2/26 and the 6:30 a.m. scheduled dose on 2/3/26 were also not administered. The next full scheduled 15 mg dose was not administered until 1:36 p.m. on 2/3/26. As a result, R1 went from 1:29 p.m. on 2/2/26 until 1:36 p.m. on 2/3/26, approximately 24 hours and 7 minutes, without receiving a full scheduled 15 mg dose of morphine, and from 5:03 p.m. on 2/2/26 until 1:36 p.m. on 2/3/26, approximately 20 hours and 33 minutes, with only a partial 7.5 mg PRN dose rather than his ordered scheduled regimen. During this period of omitted and delayed scheduled morphine dosing, R1 experienced severe pain, increased anxiety, sweating, and functional decline, according to resident interview, family interview, staff interview, and record review. These findings were consistent with possible early opioid withdrawal; however, the facility did not complete a comprehensive assessment for opioid withdrawal symptoms. During a phone interview on 2/25/26 at 11:42 a.m., RN-B stated she worked the day shift on 2/3/26 on R1's unit. RN-B reported she had not been informed by the night shift that R1 had missed two doses of morphine the previous evening and that no medication was available for his morning dose. As (continued on next page) |

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | a result, she did not contact the on-call provider until after 10:00 a.m., once she became aware he was out of morphine. RN-B stated she spoke with TRNO-A and requested a refill for R1's morphine. TRNO-A initially thought NP-A had processed the refill the previous night. Upon learning the prescription had not gone through, TRNO-A sent a message to CPA-A to have it filled and to obtain a dose from the E-kit. RN-B stated that when she entered R1's room to administer his morning medications, he asked if his morphine was available and indicated it had been out, remarking that it felt like a week to him. She documented R1's pain at a level 7 out of 10, noting it was significant for him and that he did not get out of bed during the shift due to pain. RN-B described R1 as very stoic, stating that staff must often prod him to report or describe his pain. She noted this was not the first time he had run out of his medications and emphasized the need for a more reliable system to prevent these occurrences in the future. RN-B stated by the time she got the actual morphine it was not given until 1:36 p.m., when she documented it. R1's Vitals Report dated 2/2/26 through 2/3/26 identified no food intake documented for either day. On 2/4/26, intake documentation reflected improved oral intake. Resident and family interviews also indicated decreased appetite during the medication gap. During an observation and interview on 2/24/26 at 9:28 a.m., R1 was dressed in pajamas and seated in his wheelchair in front of a card table in his room, watching the news on the television. He was noted to have an above-the-knee amputation on his left leg. R1 indicated he was a Navy war medic from the Vietnam War era and that his left lower leg was blown off when he stepped on a landmine over 57 years ago. He stated that he sustained several pieces of shrapnel to his left leg, groin, and both arms, which could not be surgically removed and continue to cause him significant pain to this day. R1 reported he receives short-acting morphine four times a day. When he receives all scheduled doses, his pain is at his baseline, which he rated as 5 out of 10. He stated that he had run out of morphine before at the facility, which he indicated happens periodically due to either staff forgetting to order it or the pharmacy not filling the prescription correctly. In the past, when the facility ran out, he was given liquid morphine, which he reported worked better for him. R1 stated that on 2/2/26, he ran out of morphine in the afternoon and did not receive it again until the following afternoon, leaving him without his scheduled doses for almost a full day. During this time, he reported his pain was a 10 out of 10, he was unable to get out of bed, and his appetite was decreased. He further stated that his anxiety worsened, making it difficult to swallow because it felt like his throat was closing. R1 reported that family member (FM)-A, his advocate, becomes upset when he does not advocate for himself because she does not want to see him in pain. He stated part of the reason he does not ask for morphine when in significant pain is that he just shuts down and does not want to bother anyone. R1 identified his biggest complaint at the facility was not having his pain medication available when he needed it. During a follow-up interview on 2/26/26 at 8:50 a.m., R1 stated that he does not like to complain about pain and tends to zone out when experiencing it. R1 did not recall waking up during the night on 2/2/26 due to pain. The following morning, he described the pain as being concentrated in his left leg and right hands, feeling as if they were being stabbed with a million knives and also affecting the back of his left leg and his groin. R1 stated that when his pain reaches that intensity, he shuts down and is unable to think clearly. He did not remember eating that day, explaining that extreme pain makes it impossible for him to function. R1 further stated that facility staff do not ask for specifics about his pain and only request a numerical rating, which he finds unhelpful and difficult for accurately describing the severity of his pain. During an interview on 2/24/26 at 10:30 a.m., FM-A stated that R1 was her husband, and they had been married for 48 years. FM-A reported that because of the shrapnel in his groin, R1 had experienced severe pain when he was at home, particularly at night, which sometimes required him to sit in a tub of hot water to help ease the pain. FM-A described the events of 2/2/26 and 2/3/26, when the facility ran out of his morphine, stating that R1 was in so much pain he even reported that his hands hurt. She noted that when R1 experienced severe pain, he loses his appetite and was unable to eat much. On that day, he was lying in bed, and the pain was particularly intense in the back of his upper left leg, running upward through the back. FM-A stated (continued on next page) |

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | that she encouraged R1 to ask for the liquid morphine, but he reported that it was unavailable as well. She added that the entire incident exacerbated his anxiety. FM-A reported that she visits R1 every day after lunch and spends a few hours with him. She also stated that R1 calls her every evening after supper to talk before going to bed. During a follow-up interview on 2/26/26 at 8:58 a.m., FM-A stated that she arrived around 12:00 p.m. to 12:30 p.m., on 2/3/26. She reported that R1 was very stoic about his pain and becomes very quiet when experiencing it. When she arrived, he was in bed, and she knew he was in pain because he was not talking much. She observed that he was sweating and that the back of his pajamas were wet. FM-A asked the nurse where the liquid morphine backup was, and the nurse stated it was not available. She noted that she did not stay long because R1 had his eyes closed, did not want to talk, and was in too much pain. Before she left, she observed R1 attempting to use the TV remote. He was unable to operate it correctly, which was unusual for him, and they were unable to watch the Westminster Kennel Club dog show as they had planned. FM-A stated that he was confused, in too much pain, and needed to rest. She found this very upsetting, knowing he was suffering and that there was nothing she could do to help. FM-A also noted that R1 did not call her that night, which was unusual because he normally calls her after supper. Review of R1's record did not identify a nursing assessment of altered mental status, cognitive change, or increased anxiety during this period During an interview on 2/24/26 at 2:09 p.m., LPN-A stated she has worked at the facility for 13 years. LPN-A explained that the process for ensuring narcotic medications do not run out is to call the on-call provider for a new prescription when there are three to four days' worth of medication remaining so it can be filled within the next day or two. She stated she was unsure how R1 could have run out of his morphine and noted that the facility has a high number of agency staff, who may not be familiar with the process for ordering narcotics. LPN-A further stated R1 has been on morphine for a long time and would be dangerous for him to miss several doses. During an interview on 2/24/26 at 3:13 p.m., the DON stated she was not aware that R1 had gone without multiple scheduled morphine doses, including omitted doses on 2/2/26 at 4:00 p.m. and 8:00 p.m. and on 2/3/26 at 6:30 a.m., with the 11:30 a.m. dose on 2/3/26 administered late at 1:36 p.m. She acknowledged that this could place R1 at risk for acute withdrawal and significant pain, representing a significant medication error. The DON noted that it did not appear the provider had been notified about the missed doses and that no orders were in place during this time to control his pain. She further stated that a medication error report was not completed because she was not aware of the incident until just now. The DON explained that the facility uses AlixaRx for ordering medications, and timely ordering was critical. She stated that if medication was unavailable, staff should contact the provider and pharmacy; in this case, it appeared to be a prescription issue. When asked what actions she would take now that she was aware of the error, the DON stated that education would be provided to ensure all nurses are familiar with the ordering process. She noted that there is a feature in the electronic medication administration record (EMAR) that allows staff to order medications electronically. The DON stated she was unsure of the root cause of this incident and will need to investigate further. She also indicated she was unsure whether R1 was comprehensively assessed for pain or withdrawal symptoms during the missed doses but noted that missing a dose would typically trigger such assessments. During a follow-up interview on 2/25/26 at 8:39 a.m., the DON stated she would have expected nursing staff to contact her if a narcotic dose for any resident was missing and confirmed that she was not notified when this occurred. The DON described the facility's narcotic tracking and refill system, noting that nurses are responsible for monitoring narcotic counts shift-to-shift and are expected to reorder medications when there are approximately five days remaining. Medications were originally reordered via stickers faxed to the pharmacy, then through the Alixa portal, and more recently electronically through Matrix within the EMAR. Once the reorder button was clicked, the pharmacy prepares the medications for overnight delivery and contacts the provider for a new prescription if needed. The DON confirmed that R1's was not monitored for withdrawal or alternative pain management when med was not available. The DON<br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | also confirmed that NP-A did not have any orders in place to comprehensively assess R1 for increased pain or opioid withdrawal symptoms. She stated that without an active prescription, medications cannot be pulled from the e-kit. Had NP-A sent the prescription electronically when contacted on 2/2/26, the medications would have been available. During a phone interview on 2/25/26 at 9:39 a.m., consultant pharmacist (CP)-A confirmed through R1's medical record that R1 had orders to receive morphine (IR) 15 mg tablets four times a day for chronic pain syndrome. CP-A verified that R1 went without morphine doses for over 18 hours and expected that this would result in increased pain. CP-A stated that staff should monitor anxiety, sweating, agitation, tremors, and tachycardia, which could indicate signs and symptoms of opioid withdrawal. CP-A confirmed through R1's medical record that there were no comprehensive assessments or monitoring for pain or acute opioid withdrawal during this period. During a phone interview on 2/26/26 at 11:04 a.m., pharmacist (P)-A stated the pharmacy received a prescription on 2/3/26 at 11:19 a.m., for 120 tablets of Morphine Immediate Release (IR) 15 mg. The prescribing provider was CPA-A. The prescription included authorization to obtain a dose from the emergency kit (e-kit) at 11:19 a.m. P-A stated the pharmacy did not receive a morphine prescription from NP-A on 2/2/26. P-A explained that prescriptions are typically sent electronically. After hours, the pharmacy allows nurses to provide the provider's contact number so the pharmacy can obtain an emergency verbal prescription for controlled substances. She stated this process has been in place for the three years she has worked there and that the pharmacy maintains 24-hour staffed pharmacists. P-A stated she was not aware of four calls reportedly made to the pharmacy on 2/2/26 during the evening hours regarding R1 and reported there were no corresponding notes in the pharmacy call log from 3:00 p.m. to 10:00 p.m., from the facility. She stated the nurse would need to specifically request an emergent controlled substance verbal order and provide the provider's contact information. After the situation involving R1 was described to her to include his reports of pain and symptoms, P-A stated this would have been considered an emergent situation and the lack of medication would have constituted an omission medication error. Regarding Morphine IR, P-A stated it generally lasts approximately 4 to 5 hours before another dose is needed, and the patient would begin exhibiting signs and symptoms of pain. She stated that being 20 hours after the last 7.5 mg dose would be considered an emergent situation. She explained that missing doses for over 20 hours significantly increases the likelihood of severe pain and early opioid withdrawal symptoms, including sweating, fevers, and chills. P-A stated she would expect nursing staff to monitor for increased pain and signs and symptoms of withdrawal after the first missed dose. Review of staff documentation and interview statements identified that facility staff reported contacting the pharmacy multiple times on 2/2/26 regarding R1's unavailable morphine prescription. However, during interview on 2/26/26, P-A stated there were no corresponding pharmacy call log notes from 3:00 p.m. to 10:00 p.m. related to R1 from the facility. Therefore, while the record supports repeated staff attempts to address the missing medication, the exact nature and documentation of all reported pharmacy contacts on 2/2/26 could not be fully verified from the pharmacy call log provided. In addition, NP-A's interview statements and documented communications were inconsistent with facility staff interviews, pharmacy records, and pharmacist interview findings, which confirmed that no morphine prescription from NP-A was received by the pharmacy on 2/2/26. These inconsistencies indicate a breakdown in prescription communication, prescription processing, and follow-up verification. During an interview on 2/26/26 at 12:18 p.m., CPA-A stated she received a message through Epic on 2/3/26 indicating that R1 was out of his morphine. She stated she electronically sent the prescription to the pharmacy that day for refill. CPA-A reported that if she had been the on-call provider on 2/2/26 when R1 needed the refill, the prescription would have been sent, and R1 would not have missed a dose. CPA-A stated that missing three 15 mg doses of (IR) morphine within a 20-hour time span would increase the likelihood of the resident experiencing increased pain. She further stated that if a dose were missed, she would enter orders for comprehensive assessment of signs and symptoms of increased pain and to be monitoring for acute opioid withdrawal symptoms.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/02/2026 |
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| NAME OF PROVIDER OR SUPPLIER St Crispin Living Community | | STREET ADDRESS, CITY, STATE, ZIP CODE 213 Pioneer Road Red Wing, MN 55066 | |

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

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| F 0755<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | During a phone interview on 2/26/26 at 12:32 p.m., the medical director stated that NP-A reported she had sent R1's morphine prescription on 2/2/26; however, the pharmacy did not receive it. He explained that if NP-A had called to obtain an emergency supply, the missed doses could have been prevented. He further stated that if he had been contacted, he could have authorized an emergency supply. He reported he was not notified of the situation at the time. The Medical Director stated that even one missed scheduled dose of (IR) morphine could result in physiological changes by approximately 9:00 p.m., as R1 did not receive his full dose. He emphasized that a missed dose should trigger nursing staff to assess and monitor escalating pain and signs and symptoms of acute opioid withdrawal. He stated the failure to notify him, and the lack of enhanced monitoring represented a breakdown in clinical oversight. Regarding pharmacology, he explained that the half-life of (IR) morphine was approximately 3 to 4 hours. He stated that it generally takes 3 to 4 half-lives for a medication to be substantially eliminated from the system, which would be approximately 16 to 20 hours. He indicated that during this time, R1 would not be in his usual state and would theoretically experience pain worse than his baseline. He identified worsening physical pain, sweating, nausea, and vomiting as expected signs and symptoms when morphine is no longer present in the system. He further noted that pulse rate may not be a reliable indicator in this case because R1 was on blood pressure medications. The Medical Director reiterated that if an emergency supply had been requested on 2/2/26, the situation could have been prevented. He emphasized that the clinical team is responsible for ensuring appropriate communication, medication availability, and monitoring when a scheduled opioid dose is missed. Reconciliation and accounting of controlled substances between the narcotic book, supply on hand, and pharmacy packing slips. During an observation and interview on 2/25/26 at 2:02 p.m. with LPN-B and the DON, a review of the Spruce Hill Unit medication cart locked drawer of controlled substances identified multiple discrepancies involving R1's morphine. 1. Controlled substance documentation incomplete (Page 69). The Controlled Substance Book, page 69, identified R1 received 24 tablets of morphine 15 mg on 2/17/26; however, the sheet did not include the RX number, prescriber name, or prescriber directions for administration. No bubble pack was present for verification, as the last tablet was documented as administered on 2/24/26 at 7:36 a.m. The pharmacy packing slip identified RX number 28373012, label 1 of 2, for 24 tablets of morphine 15 mg delivered on 2/17/26; however, the packing slip did not identify a delivery time. 2. Discrepancy in quantity received and incomplete documentation (Page 70).R1's morphine 15 mg bubble pack labeled RX number 28373012, label 2 of 2, directed to take one-half tablet (7.5 mg) twice daily as needed, showed 6 half-tablets remaining. Numbers 7 through 12 on the bubble pack were empty and no longer sealed, with handwritten initials by each corresponding number. The Controlled Substance Book, page 70, documented that 12 tablets were received on 2/17/26, but did not indicate these were to be administered as half-tablets (7.5 mg). The sheet also lacked the RX number, prescriber, and prescriber directions. Documentation indicated doses were administered on 2/24/26 at 12:25 p.m., 4:00 p.m., and 8:00 p.m., with 6 tablets remaining. The pharmacy packing slip for RX number 28373012, label 2 of 2, identified a quantity of 6 tablets delivered on 2/17/26, indicating a discrepancy between the pharmacy delivery record (6 tablets) and the Controlled Substance Book documentation (12 tablets received). 3. Discrepancy in quantity received (Page 78).R1's morphine 15 mg bubble pack labeled |