Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H54492281M
Compliance #: H54495323C

Date Concluded: June 10, 2026

Name, Address, and County of Licensee Investigated:
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066
Goodhue County

Facility Type: Nursing Home

Evaluator's Name:
Katherine Barnhardt RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.

Initial Investigation Allegation(s):
The facility neglected the resident when the facility failed to provide morphine medication as ordered.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to reorder the resident's morphine (pain medication) before the supply ran out. The resident missed three scheduled 15-milligram doses of morphine which caused the resident to decline meals and experience an increase in pain. In addition, the investigation revealed when the resident received his morphine from pharmacy, facility staff administered two consecutive 30-milligram doses instead of 15-milligram doses of morphine. The facility's medication processes failed to meet reasonable and necessary expectations to maintain the resident's physical and mental needs.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted a family member and a provider. The investigation

included review of the resident record(s), pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures.

The resident resided in a skilled nursing facility. The resident's diagnoses included above the knee amputation, anxiety and chronic pain. The resident's care plan included assistance with medication management and administration. The resident's assessment indicated assistance with toileting, bathing and activities of daily living. The resident used an electric wheelchair for ambulation and a mechanical lift for transfers. The resident was cognitively intact, alert and oriented.

The resident's record indicated for years the resident used morphine 15 milligrams orally four times daily for pain management. The resident record indicated when the resident had increased and unmanaged pain the resident isolated and withdrew from activities. The resident record indicated when a 15-milligram dose was due, the resident received a 7.5 milligram dose and did not have morphine available for the next three consecutive doses due. Additionally, when pharmacy delivered the morphine, two medication errors occurred and the resident was administered twice the ordered dose.

Progress notes indicated licensed staff requested a refill of the resident's morphine when the supply was down to a 7.5 milligram tab. Licensed staff administered the half dose and contacted pharmacy for a refill. Progress notes indicated pharmacy required a new refill order from a provider. Progress notes indicated on day two the resident's morphine was still unavailable, and a licensed staff requested pharmacy approval to administer a 15-milligram dose from an emergency supply. Access to the emergency supply was granted when the pharmacy received a new prescription. The resident received a 15-milligram dose from the emergency supply after three missed doses.

The resident's pain monitoring record indicated the resident's pain level was checked every shift. Pain monitoring indicated that the resident experienced no pain to mild pain every shift until the resident's morphine was unavailable. When the resident's morphine was unavailable the resident reported severe pain seven out of ten intensity.

An internal investigation concluded the resident's morphine supply ran out and the resident missed three consecutive morphine doses.

During an interview, licensed staff stated the resident's morphine reorder process was inconsistent. Some staff would pull the reorder sticker off the morphine package ordering too early, and pharmacy would reject the refill request. When the reorder sticker was removed from the morphine package facility staff thought it was already ordered. Licensed staff stated the resident's morphine was unavailable for three doses. Licensed staff stated the resident's morphine had been packaged in 7.5 milligram tabs however when the refill package arrived and was put in the medication cart the morphine was packaged in 15 milligram tabs. Licensed staff

had not completed dose verification of the morphine tabs and administered two 30-milligram (double doses) two consecutive times before the package change was noticed.

During an interview, licensed leadership stated the facility's policy was to reorder the resident's morphine medication when the supply had five days left. Licensed leadership stated the missed morphine doses had not been reported to her and facility staff should have known the supply was low. The morphine was counted every shift as part of narcotic control. Facility staff phoned a provider and a pharmacy multiple times when it was discovered the resident had one 7.5 milligram dose available. Licensed leadership stated the resident missed three doses of morphine, did not get up for breakfast or lunch and may have had a "slight" increase in pain. Licensed leadership stated four days after the resident's morphine supply was resolved, a second morphine incident occurred. Facility staff administered two consecutive 30-milligram doses of morphine to the resident, which was double the amount of morphine the resident was ordered to receive.

During an interview, a family member stated when the resident's morphine medication was unavailable the resident "hurt so bad." The resident did not engage with visitors, withdrew from favorite activities and did not get out of bed. The resident reported to family he "hurt allover" and was not sleeping. A family member stated the resident took three days to recover from the missed morphine doses.

During an interview conducted by a federal surveyor, the resident stated the facility had run out of his morphine and he did not like to complain about pain. The resident stated when he is in that much pain he shuts down because "I can't think straight". The resident stated he was in "too much pain" to eat or get out of bed when the morphine was unavailable.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Interviewed by federal surveyor

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility notified the provider and reviewed medication processes.

Action taken by the Minnesota Department of Health:

MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Goodhue County Attorney
Red Wing City Attorney
Red Wing Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **05/05/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CRISPIN LIVING COMMUNITY	**213 PIONEER ROAD , RED WING, Minnesota, 55066**

(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please	20000		

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

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20000	Continued from page 1 refer to the public maltreatment report for details.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H54492281M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for #H54492281M, tag identification 1850. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	21850		