Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2026

Administrator
St Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

Re: Reinspection Results
Event ID: 1F188D-H1

Dear Administrator:

On March 31, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 2, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2026

Administrator
St. Crispin Living Community
213 Pioneer Road
Red Wing, MN 55066

RE: CCN: 245449
Cycle Start Date: March 2, 2026

Dear Administrator:

On March 12, 2026, we notified you a remedy was imposed.

On May 7, 2026, the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 1, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective March 27, 2026, be discontinued as of April 1, 2026. (42 CFR 488.417 (b))

In our letter of March 12, 2026, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 27, 2026. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted

March 12, 2026

Administrator
ST CRISPIN LIVING COMMUNITY
213 PIONEER ROAD
RED WING, MN 55066

RE: CCN: 245449
Cycle Start Date: March 2, 2026

Dear Administrator:

On March 2, 2026, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On February 27, 2026, the situation of immediate jeopardy to potential health and safety cited at F755 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 27, 2026.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 27, 2026, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 27, 2026, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare / Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 27, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, ST CRISPIN LIVING COMMUNITY will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 27, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 2, 2026 (six months after the identification of noncompliance), if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown at (312) 353-1502. Information may also be emailed to tamika.brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0000	INITIAL COMMENTS On 2/24/26, 2/25/26, 2/26/26 and 3/2/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H54495323C (2734211) with deficiencies issued at F609, F697, and F710. The survey resulted in an Immediate Jeopardy (IJ) at F755 when the facility failed to implement appropriate pharmacy services so that R1's prescribed morphine was available for administration which caused R1 severe pain that was more than transient. The IJ began on 2/2/26, and the immediacy was removed on 2/27/26. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily	F0609		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0609 SS = D	Continued from page 1 injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: 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	F0609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0609 SS = D	Continued from page 2 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 neglect must be reported to the Minnesota Department of Health (MDH) via the online reporting system immediately upon receiving the report.	F0609		
F0697 SS = D	Pain Management	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 3 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: 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 1/30/26, 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	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 4 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 2/3/26 /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. 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	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 5 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	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 6 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 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.	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 7 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	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 8 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 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	F0697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0697 SS = D	Continued from page 9 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.	F0697		
F0710 SS = F	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is NOT MET as evidenced by: 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	F0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0710 SS = F	Continued from page 10 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.,	F0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0710 SS = F	Continued from page 11 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 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	F0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0710 SS = F	Continued from page 12 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	F0710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0710 SS = F	Continued from page 13 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.	F0710		
F0755 SS = J	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by:	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 14 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 15 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 1/30/26, 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 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 16 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 17 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 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 18 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 19 prescription needed to be sent again Facility 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 20 shift that R1 had missed two doses of morphine the previous evening and that no medication was available for his morning dose. As 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 21 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 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 22 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 23 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 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 24 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 25 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. 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 26 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).	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 27 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 RX number 28387401, label 1 of 2, directed to take one tablet by mouth four times daily, showed 27 tablets remaining. Numbers 28 and 29 were empty and no longer sealed. The Controlled Substance Book, page 78, documented that 29 tablets were received on 2/25/26 at 6:50 a.m., with one dose administered at 7:34 a.m. and another at 12:26 p.m., reflecting 27 tablets remaining. However, the pharmacy packing slip for RX number 28387401, label 1 of 2, documented that 28 tablets were delivered on 2/25/26 at 6:50 a.m., indicating a discrepancy of one tablet. During an interview on 2/25/26 at 2:08 p.m., LPN-B stated that when reconciling controlled substances upon delivery, the nurse should compare each bubble pack to the pharmacy packing slip to ensure the correct number of tablets is received. If discrepancies are identified, they should be addressed at the time of delivery. LPN-B stated that if the packing slip is correct, the verifying nurse signs and dates it, and the slip is retained in a three-ring binder at the desk for approximately two weeks before being destroyed. LPN-B further stated that the nurse is responsible for documenting on the controlled substance sheet the resident's name, medication, dosage, directions, RX number, and quantity received, and writing the corresponding narcotic book page number on the bubble pack. LPN-B acknowledged she received R1's morphine bubble pack the morning of 2/25/26 and did not identify that the packing slip documented 28 tablets while the	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 28 Controlled Substance Book reflected 29 tablets received. She stated the discrepancy should have been addressed at the time of delivery. During an interview on 2/25/26 at 2:21 p.m., the DON reiterated the facility's reconciliation process and stated that pharmacy labels should be affixed to all controlled substance sheets. If the label is not available, the RX number, prescribing practitioner, medication name, strength, and directions for use should be documented on the sheet. The DON verified this was not completed for pages 69 and 70 for R1 and stated this increases the risk for medication errors and potential drug diversion. Policy was reviewed and does not reflect its actual workflow practices and presents gaps that does not address the facility's use of electronic systems, such as the AlixaRx portal or Matrix EMAR, for submitting new prescriptions or reorders. It lacks clear guidance for proactive monitoring of missed or delayed doses, escalating urgent medication needs, or tracking new prescriptions to ensure timely administration. Facility Policy entitled, "Organizational Aspects – Provider Pharmacy Requirements," revised August 2014, identified that regular and reliable pharmaceutical service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. A written agreement with the provider pharmacy is maintained, and the pharmacy is appropriately licensed, maintains required professional credentials and liability insurance, and is responsible for rendering required services in accordance with local, state, and federal laws, facility policies, and professional standards. The provider pharmacy agrees to assist the facility in determining appropriate equipment and packaging, develop and implement pharmaceutical policies with the consultant pharmacist, accurately dispense medications based on authorized prescriber orders, supply medications packaged to meet facility needs, provide only USP-NF approved medications, label all medications according to policy and regulatory requirements, provide routine and timely pharmacy service as contracted, and provide emergency/STAT medications 24 hours per day, seven days per week. Emergency or STAT medications are available as soon as reasonably possible after the order is received, and all other new orders are received and available for administration on the next routine delivery or from the electronic	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 29 medication cabinet or emergency kit. The provider pharmacy also performs initial medication use assessments for new residents, maintains a medication profile including age, diagnoses, weight, condition, allergies, and other pertinent information, reviews each resident profile prior to dispensing, screens each new order for appropriate indication, interactions, duplication, dose, interval, and route, and notifies nursing staff if information is missing. The pharmacy provides medication information and consultation to nursing staff, implements procedures when delivery is delayed or medications are unavailable, provides, maintains, and replenishes emergency medication supply, and assists prescribers in documenting medical necessity for non-formulary or non-covered medications or providing therapeutic alternatives. Policy reviewed and lacked facility-level procedures to ensure timely ordering and receipt of medications, monitoring for low supply, escalation for urgent needs, and integration with current electronic prescription and MAR systems. Facility Policy entitled, “Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy,” revised August 2014, identified that medications and related products are received from the dispensing pharmacy on a timely basis and accurate records of medication order and receipt are maintained. Medication orders are written on a pharmacy-provided form, electronically, or via telephone order and include the date ordered, whether the order is new or a refill, the resident’s name and identifying information, medication name and strength, indication for use, directions for use, and the pharmacy supplier if different from the provider pharmacy. Repeat medications are reordered according to the pharmacy’s delivery schedule, typically five days in advance, and the nurse who reorders is responsible for notifying the pharmacy of any changes in directions or labeling errors. Orders are transmitted to the pharmacy via phone, fax, or electronically, and when available, the pharmacy label is pulled and transmitted to the pharmacy. Stat or emergency medications during regular pharmacy hours are phoned, faxed, or sent electronically and administered as soon as reasonably possible, with initial doses obtained from the emergency kit if necessary; after-hours orders follow the Emergency Pharmacy Service and Kits Policy. Upon receipt of medications, a licensed nurse documents delivery, verifies the medications and directions for use, promptly reports any discrepancies to the pharmacy	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245449	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/02/2026

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
F0755 SS = J	Continued from page 30 and charge nurse, immediately secures the medications in the appropriate storage area, and ensures medications are incorporated into the resident's allocation prior to the next medication pass. Delivery records are retained for a minimum of one year or as required by state law. Policy reviewed and lacked guidance on monitoring for missed or delayed doses, tracking low medication inventory, and proactive communication with prescribers or pharmacy when medications are unavailable. It also does not reflect the facility's current electronic medication ordering workflow, such as using EMAR or AlixaRx, The immediate jeopardy that began on 2/2/26 was removed on 2/27/26 when it was verified that the facility implemented the following:Policies were reviewed, revised, and/or developed regarding medication ordering and receiving from pharmacy, receiving controlled substances, and procedures for reordering controlled substance medications.All residents who received scheduled and PRN controlled substance medications were reviewed back to 2/1/26 for administration compliance.All medication carts and narcotic books were reconciled to ensure controlled substance medications were accurate, matched active orders, and were readily available for dispensing.All narcotic books were reconciled to ensure complete accuracy, including prescription numbers and administration directions.Pharmacy reports were reviewed, and new prescription refills were requested for all residents with remaining refill quantities of zero.Education was provided to all licensed facility staff, including agency staff, prior to their shifts on medication ordering and receipt procedures, receiving controlled substances, reordering procedures, and when to contact the facility medical director.A double-check system was implemented in collaboration with AllixaRx to ensure medications are ordered timely. The pharmacy will generate a weekly controlled reorder report, which will be sent to the DON for review. In addition, the DON will track all medication orders to ensure timely receipt and availability for residents.Facility prescribing medical providers were educated by the medical director on expectations for prescribing, pharmacy protocols, e-kits, substitutions after hours, and responding to urgent after-hours calls 24/7.	F0755		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 12, 2026

Administrator
ST CRISPIN LIVING COMMUNITY
213 PIONEER ROAD
RED WING, MN 55066

Re: State Nursing Home Licensing Orders
Event ID: 1F188D-H1

Dear Administrator:

The above facility survey was completed on March 2, 2026, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion, and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/ rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors' findings are the Suggested Method of Correction and the Time Period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must 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. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
St. Paul, MN 55164-0899
Office: 651-201-4384 | Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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: On 2/24/26, 2/25/26, 2/26/26 and 3/2/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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	Continued from page 1 The following complaint was reviewed: H54495323C (2734211). Licensing orders were issued at 0830 and 1550 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 2 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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 1/30/26, 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	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 3 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 2/3/26 /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. 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.	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 4 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	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 5 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 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.,	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 6 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,	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 7 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 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	20830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
20830	Continued from page 8 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. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures, train staff, and implement measures to prevent and/or minimize medication errors, missed treatments, and improved communication, for residents at risk to assure they are receiving the necessary medications. The director of nursing or designee could conduct random audits of pain assessments; to ensure appropriate care and services are implemented. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	20830		
21550	Adminiatration of Medications; Pharmacy Serv. CFR(s): MN Rule 4658.1325 Subp. 1 Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services. This LICENSURE REQUIREMENT is NOT MET as evidenced by: 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 9 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 1/30/26, 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.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 10 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 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 11 “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.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 12 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 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.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 13 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 again Facility 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 14 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 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 15 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 16 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 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 17 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.	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 18 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 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 19 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 20 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. 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	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 21 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 RX number 28387401, label 1 of 2, directed to take one tablet by mouth four times daily, showed 27 tablets remaining. Numbers 28 and 29 were empty and no longer sealed. The Controlled Substance Book, page 78, documented that 29 tablets were received on 2/25/26 at 6:50 a.m., with one dose administered at 7:34 a.m. and another at 12:26 p.m., reflecting 27 tablets remaining. However, the	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 22 pharmacy packing slip for RX number 28387401, label 1 of 2, documented that 28 tablets were delivered on 2/25/26 at 6:50 a.m., indicating a discrepancy of one tablet. During an interview on 2/25/26 at 2:08 p.m., LPN-B stated that when reconciling controlled substances upon delivery, the nurse should compare each bubble pack to the pharmacy packing slip to ensure the correct number of tablets is received. If discrepancies are identified, they should be addressed at the time of delivery. LPN-B stated that if the packing slip is correct, the verifying nurse signs and dates it, and the slip is retained in a three-ring binder at the desk for approximately two weeks before being destroyed. LPN-B further stated that the nurse is responsible for documenting on the controlled substance sheet the resident's name, medication, dosage, directions, RX number, and quantity received, and writing the corresponding narcotic book page number on the bubble pack. LPN-B acknowledged she received R1's morphine bubble pack the morning of 2/25/26 and did not identify that the packing slip documented 28 tablets while the Controlled Substance Book reflected 29 tablets received. She stated the discrepancy should have been addressed at the time of delivery. During an interview on 2/25/26 at 2:21 p.m., the DON reiterated the facility's reconciliation process and stated that pharmacy labels should be affixed to all controlled substance sheets. If the label is not available, the RX number, prescribing practitioner, medication name, strength, and directions for use should be documented on the sheet. The DON verified this was not completed for pages 69 and 70 for R1 and stated this increases the risk for medication errors and potential drug diversion. Policy was reviewed and does not reflect its actual workflow practices and presents gaps that does not address the facility's use of electronic systems, such as the AlixaRx portal or Matrix EMAR, for submitting new prescriptions or reorders. It lacks clear guidance for proactive monitoring of missed or delayed doses, escalating urgent medication needs, or tracking new prescriptions to ensure timely administration. Facility Policy entitled, "Organizational Aspects – Provider Pharmacy Requirements," revised August 2014, identified that regular and reliable pharmaceutical	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 23 service is available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. A written agreement with the provider pharmacy is maintained, and the pharmacy is appropriately licensed, maintains required professional credentials and liability insurance, and is responsible for rendering required services in accordance with local, state, and federal laws, facility policies, and professional standards. The provider pharmacy agrees to assist the facility in determining appropriate equipment and packaging, develop and implement pharmaceutical policies with the consultant pharmacist, accurately dispense medications based on authorized prescriber orders, supply medications packaged to meet facility needs, provide only USP-NF approved medications, label all medications according to policy and regulatory requirements, provide routine and timely pharmacy service as contracted, and provide emergency/STAT medications 24 hours per day, seven days per week. Emergency or STAT medications are available as soon as reasonably possible after the order is received, and all other new orders are received and available for administration on the next routine delivery or from the electronic medication cabinet or emergency kit. The provider pharmacy also performs initial medication use assessments for new residents, maintains a medication profile including age, diagnoses, weight, condition, allergies, and other pertinent information, reviews each resident profile prior to dispensing, screens each new order for appropriate indication, interactions, duplication, dose, interval, and route, and notifies nursing staff if information is missing. The pharmacy provides medication information and consultation to nursing staff, implements procedures when delivery is delayed or medications are unavailable, provides, maintains, and replenishes emergency medication supply, and assists prescribers in documenting medical necessity for non-formulary or non-covered medications or providing therapeutic alternatives. Policy reviewed and lacked facility-level procedures to ensure timely ordering and receipt of medications, monitoring for low supply, escalation for urgent needs, and integration with current electronic prescription and MAR systems. Facility Policy entitled, “Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy,” revised August 2014, identified that medications and related products are received from the dispensing pharmacy on a timely basis and accurate	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 24 records of medication order and receipt are maintained. Medication orders are written on a pharmacy-provided form, electronically, or via telephone order and include the date ordered, whether the order is new or a refill, the resident's name and identifying information, medication name and strength, indication for use, directions for use, and the pharmacy supplier if different from the provider pharmacy. Repeat medications are reordered according to the pharmacy's delivery schedule, typically five days in advance, and the nurse who reorders is responsible for notifying the pharmacy of any changes in directions or labeling errors. Orders are transmitted to the pharmacy via phone, fax, or electronically, and when available, the pharmacy label is pulled and transmitted to the pharmacy. Stat or emergency medications during regular pharmacy hours are phoned, faxed, or sent electronically and administered as soon as reasonably possible, with initial doses obtained from the emergency kit if necessary; after-hours orders follow the Emergency Pharmacy Service and Kits Policy. Upon receipt of medications, a licensed nurse documents delivery, verifies the medications and directions for use, promptly reports any discrepancies to the pharmacy and charge nurse, immediately secures the medications in the appropriate storage area, and ensures medications are incorporated into the resident's allocation prior to the next medication pass. Delivery records are retained for a minimum of one year or as required by state law. Policy reviewed and lacked guidance on monitoring for missed or delayed doses, tracking low medication inventory, and proactive communication with prescribers or pharmacy when medications are unavailable. It also does not reflect the facility's current electronic medication ordering workflow, such as using EMAR or AlixaRx, The immediate jeopardy that began on 2/2/26 was removed on 2/27/26 when it was verified that the facility implemented the following:Policies were reviewed, revised, and/or developed regarding medication ordering and receiving from pharmacy, receiving controlled substances, and procedures for reordering controlled substance medications.All residents who received scheduled and PRN controlled substance medications were reviewed back to 2/1/26 for administration compliance.All medication carts and narcotic books were reconciled to ensure controlled substance medications were accurate, matched active orders, and were readily available for dispensing.All narcotic books were	21550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/02/2026**

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
21550	Continued from page 25 reconciled to ensure complete accuracy, including prescription numbers and administration directions.Pharmacy reports were reviewed, and new prescription refills were requested for all residents with remaining refill quantities of zero.Education was provided to all licensed facility staff, including agency staff, prior to their shifts on medication ordering and receipt procedures, receiving controlled substances, reordering procedures, and when to contact the facility medical director.A double-check system was implemented in collaboration with AllixaRx to ensure medications are ordered timely. The pharmacy will generate a weekly controlled reorder report, which will be sent to the DON for review. In addition, the DON will track all medication orders to ensure timely receipt and availability for residents.Facility prescribing medical providers were educated by the medical director on expectations for prescribing, pharmacy protocols, e-kits, substitutions after hours, and responding to urgent after-hours calls 24/7. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for pharmacy services, and how controlled substance medication is ordered, transcribed, delivered and dispensed by the pharmacy. The director of nursing or designee could develop a system to educate staff about pharmacy services and the disposition of the medication. The quality assurance committee could monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	21550		