DEPARTMENT OF HUMAN SERVICES

April 19, 2023

Blake Elliott, Authorized Agent
Bridges MN
1932 University Avenue West
Saint Paul, Minnesota 55104

License Number: 1079030 (Home and Community-Based Services)
Community Residential Site: 1080200

License Complaint Report Number: 202209428

CORRECTION ORDER

Dear Blake Elliott:

A licensing complaint investigation of Bridges MN, located at 851 Redwood Lane, New Brighton, Minnesota, was conducted to determine compliance with state and federal laws and rules governing the provision of home and community-based services to persons with disabilities and age 65 and older under Minnesota Statutes, Chapter 245D. As a result of the licensing complaint investigation(s) a Correction Order is being issued.

A. Reason for Correction Order

Pursuant to Minnesota Statutes, section 245A.06, if the Commissioner of the Department of Human Services (DHS) finds that the license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the Commissioner may issue a Correction Order to the license holder.

The following violation(s) of state or federal laws and rules were determined as a result of the licensing review. Corrective action for each violation is required by Minnesota Statutes, section 245A.06 and is hereby ordered by the Commissioner of Human Services.

1. Citation: Minnesota Statutes, section 245D.081, subdivision 2 and 3.

Violation: For one of one person whose record was reviewed (P1), the license holder did not provide program management and oversight of the services provided by the license holder as required.

The license holder failed to:

- provider oversight of the license holder's responsibility assigned in P1's support plan and support plan addendum. See citations 2 and 3 for evidence of failures; and
- provide program management and oversight of the services provided by the license holder. See citations 2 through 5 for the license holder's failures to provide supervision, support and evaluation of activities, including:
    - maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section 256B.04, subdivision 21, paragraph (b); and
    - ensuring the duties of the designated coordinator are fulfilled according to the requirements in subdivision 2.

Repeat Violation: The license holder was cited for a similar violation in an Order of License Revocation, Determinations of Maltreatment, and Failure to Report Maltreatment dated June 27, 2022; in an Order of Conditional Order March 10, 2020; and in correction orders dated June 14, 2019, December 27, 2019, March 12, 2020, May 20, 2021, June 3, 2022, October 14, 2022, November 4, 2022, November 10, 2022, and March 31, 2023.

Corrective Action Ordered: Because the license is currently revoked, operating under appeal, you must:

- share this correction order with the person, the person's legal representative, and the person's case manager; and
- inform each of how you will maintain compliance with this licensing requirement on a continuing basis; and
- submit, to the licensor identified in this correction order, evidence showing that the above-mentioned requirements have been completed.

On an ongoing basis, you must maintain compliance as required.

2. Citation: Minnesota Statutes, section 245D.05, subdivision 2, paragraph (b).

Violation: For one person served (P1), the license holder did not implement medication administration procedures as required.

The license holder was assigned the responsibility for medication administration in P1's support plan addendum. P1 was prescribed Lorazepam 1mg tablet to be given as needed when P1 was displaying target symptoms. On October 28, 2022, SP1 administered Lorazepam to P1 because of an increase in P1's target symptoms. However, SP1 administered a liquid form of lorazepam that was not prescribed to P1. The liquid form was prescribed to another person residing in P1's community residential site.

In a general event report (GER) completed by the license holder regarding the medication error on October 25, 2022, SP1 reported P1's medication administration record (MAR) needed updating because P1's MAR listed lorazepam was documented as a 1mg tablet instead of 2mg/mL liquid. SP1 erroneously believed that the dosage and form of the medication documented on P1's MAR was incorrect and that they administered the correct form and dosage of medication when they administered another person's prescribed 2 mg/mL liquid lorazepam to P1

The license holder's "Safe Medication Assistance and Administration" policy and procedure documented the following medication procedures that staff were to follow to ensure a person takes medications and treatments as prescribed. SP1 failed to:

- compare the medication sheet with the label of P1's lorazepam to ensure the following:
  - right person;
  - right medication; and
  - right dose;
- verify the discrepancy, prior to administering the lorazepam, of the medication by contacting the nurse, pharmacist, or prescriber;
- compare the label with the medication sheet for a second time; and
- compare the label with the medication sheet for the third time before administering it.

Repeat Violation: The license holder was cited for similar violation in an Order of Conditional Order March 10, 2020; and in correction orders dated December 27, 2019, October 7, 2020, February 5, 2021, April 2, 2021, November 9, 2021, February 25, 2022, November 10, 2022, November 22, 2022, November 30, 2022, and March 31, 2023.

Corrective Action Ordered: Because the license is currently revoked, operating under appeal, you must:

- share this correction order with the person, the person's legal representative, and the person's case manager; and

- inform each of how you will maintain compliance with this licensing requirement on a continuing basis; and
- submit, to the licensor identified in this correction order, evidence showing that the above-mentioned requirements have been completed.

On an ongoing basis, you must maintain compliance as required.

3. Citation: Minnesota Statutes, section 245D.05, subdivision 4.

Violation: For one person whose record was reviewed (P1), the license holder did not review medication administration records (MAR's) as required.

a. The license holder maintained a document titled "Medication Administration Record Review" in P1's record dated October 29, 2022, that contained a review of P1's medication administration records from July, August, and September of 2022. According to the internal review conducted by the license holder, the medication administration record review identified 44 medication errors for the months of July to September 2022. When a DHS licensor reviewed P1's MARs for that time period, the licensor discovered additional medication errors that were not identified in the MAR review the license holder completed on October 29, 2022. Although the license holder conducted the MAR review, the license holder failed to identify all of the medication administration errors.

Additionally, the license holder documented on P1's MAR review that the corrective action related to the medication errors occurred on October 25, 2022; however, the MAR review was not completed until October 29, 2022. A DHS licensor was unable to determine if or when corrective action occurred. The license holder failed to develop and implement a plan to correct patterns of medication administration errors when identified.

b. The license holder was responsible for reporting P1's refusal or failure to take or receive medication or treatment as prescribed. P1's support plan addendum dated December 12, 2022, stated that the license holder was to report medication refusals or failures to take medications within 5 business days as they occur to P1's legal representative and case manager. The license holder failed to report several occurrences where P1 refused to take medications or treatments and P1's failure to receive medications and treatment as prescribed to P1's legal representative and case manager within 5 business days as they occurred.

Repeat Violation: The license holder was cited for similar violation in an Order of Conditional Order March 10, 2020; and in correction orders dated May 1, 2019, June 14, 2019, December 27, 2019, February 5, 2021, May 20, 2021, December 6, 2021, and February 25, 2022.

Corrective Action Ordered: Because the license is currently revoked, operating under appeal, you must:

- share this correction order with the person, the person's legal representative, and the person's case manager; and
- inform each of how you will maintain compliance with this licensing requirement on a continuing basis; and
- submit, to the licensor identified in this correction order, evidence showing that the above-mentioned requirements have been completed.

On an ongoing basis, you must maintain compliance as required.

4. Citation: Minnesota Statutes, section 245D.095, subdivision 3.

Violation: For one person whose record was reviewed (P1), the license holder did not maintain a service recipient record as required.

> During a site visit on February 3, 2023, a DHS licensor requested P1's health and daily notes for the months of July, August, and September of 2022. The license holder reported P1's health and daily notes for those months were missing. The license holder failed to protect P1's service recipient record against loss.

Repeat Violation: The license holder was cited for similar violations in a correction order dated November 22, 2022.

Corrective Action Ordered: Because the license is currently revoked, operating under appeal, you must:

- share this correction order with the person, the person's legal representative, and the person's case manager; and
- inform each of how you will maintain compliance with this licensing requirement on a continuing basis; and
- submit, to the licensor identified in this correction order, evidence showing that the above-mentioned requirements have been completed.

On an ongoing basis, you must maintain compliance as required.

5. Citation: Minnesota Statutes, section 245D.11, subdivision 2, paragraph (2) and (3).

Violation: One person whose record was reviewed (P1), the license holder did not ensure the program and program staff enforced the program's policy and procedures on safe medication assistance and administration as required.

The license holder's policy and procedure titled "Policy and Procedure on Safe Medication Assistance and Administration" required the license holder to ensure the following when assigned the responsibility for administering medication:

- Regarding the verification and monitoring of effectiveness of systems to ensure safe medication administration reporting and reviewing:
  - The designated person will be responsible for reviewing each person's medication administration record to ensure information is current and accurate. This will include a review of the monthly medication sheets, referrals, medication orders, etc;
  - At a minimum, this review will occur quarterly or more frequently if directed by the person and/or legal representative of the support plan or support plan addendum;
  - Based upon this quarterly or more frequent review, the reviewer will notify the manager, as needed, of any issues. Collaboratively, a plan must be developed and implemented to correct patterns of medication administration errors or systematic errors when identified. When needed, staff training will be included as part of this plan to correct identified errors; and
  - The following information will be reported to the legal representative and case manager as they occur or as directed by the support plan or support plan addendum:
    - A person's refusal or failure to take or receive medication or treatment as prescribed; and
    - Any reports as required, regarding if a dose of medication is not administered or treatment is not performed as prescribed, whether by staff error, the person's error, or by the person's refusal.

- Regarding the handling of changes to prescriptions and the implementation of the prescription changes:
  - All written instructions regarding changes to medications and treatments are required to be documented through a prescription label or the prescriber's written or electronically recorded order for the prescription;
  - Changes made to prescriptions will be immediately communicated to the manager and nurse, as applicable;
  - Staff will implement changes and document appropriately on the monthly medication sheet; and
  - Discontinued medications or medications that the dosage is no longer accurate due to the changes will be discarded appropriately.

- Regarding the coordination and communication with prescribers:
  - All prescriber instructions will be implemented as directed within required timelines by staff and/or the person served and documented in related health documentation

The license holder failed to enforce the above-mentioned policy when assigned the responsibility for the administration of P1's medications.

<u>Repeat Violation</u>: The license holder was cited for similar violation in an Order of Conditional Order March 10, 2020; and in correction orders dated February 5, 2021, and February 25, 2022, November 4, 2022, November 10, 2022, and November 30, 2022.

<u>Corrective Action Ordered</u>: Because the license is currently revoked, operating under appeal, you must:

- share this correction order with the person, the person's legal representative, and the person's case manager; and
- inform each of how you will maintain compliance with this licensing requirement on a continuing basis; and
- submit, to the licensor identified in this correction order, evidence showing that the above-mentioned requirements have been completed.

On an ongoing basis, you must maintain compliance as required.

If you fail to correct the violations specified in the Correction Order within the prescribed time lines the Commissioner may impose a fine and order other licensing sanctions pursuant to Minnesota Statutes, sections 245A.06 and 245A.07.

Submissions required as part of a corrective action ordered must be sent to your Licensor at:

1. By secure email at Elizabeth.Schiefelbein@state.mn.us; or
2. If you are unable to submit corrective action ordered securely through email, you can mail or fax using the information below:

Commissioner, Department of Human Services
ATTN: Liz Schiefelbein
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

B. Right to Request Reconsideration

If you believe any of the citations are in error, you have the right to request that the Commissioner of Human Services reconsider the parts of the Correction Order that you believe to be in error. The request for reconsideration must be in writing and received by the Commissioner within 20 calendar days after receipt of this report. Your request for reconsideration must be sent to:

Commissioner, Department of Human Services
Office of Inspector General
Legal Counsel's Office
Attn: Licensing Legal Unit
PO Box 64953
St. Paul, MN 55164-0953

Please note that a request for reconsideration does not stay any provisions or requirements of the Correction Order. The Commissioner's disposition of a request for reconsideration is final and not subject to appeal under Minnesota Statutes, chapter 14.

If you have any questions regarding this Correction Order, please contact me as soon as possible.

Liz Schiefelbein, Human Services Licensor
Licensing Division
Office of Inspector General
651-431-2738