

May 16, 2025

Akinbowale John Barbington, Authorized Agent  
New Hope Living & Nursing Services  
6901 78 Avenue North  
Brooklyn Park, Minnesota 55445-2720

Investigation Report Number: 202502896  
License Number: 1070370 (245D – HCBS)  
1070372 (CRS – HCBS)

### **CORRECTION ORDER**

Dear Akinbowale John Barbington:

On April 15, 2025, a licensing investigation of New Hope Living & Nursing Services, located at 6901 78 Avenue North, Brooklyn Park, 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 this licensing investigation, 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 investigation. 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.05, subdivision 1.

Violation: For one of one person whose record was reviewed (P1), the license holder did not document how health services would be met as required.

- a. The license holder was responsible for meeting P1's health service needs as assigned in P1's support plan and support plan addendum. The license holder failed to maintain documentation in P1's support plan addendum of the following:
  - P1 was prescribed a pro re nata (PRN) psychotropic medication. The license holder failed to maintain documentation on how P1's health needs would be met in P1's support plan addendum, including a description of the procedures the license holder would follow in order to administer P1's PRN psychotropic medication.
  - The license holder failed to follow the documented procedures in P1's support plan addendum on how the license holder would assist with or coordinate medical appointments for P1, which resulted in several of P1's medications running out.
  - The license holder stored an injectable medication for P1 that P1 self-administered every twelve weeks. The license holder failed to maintain documentation on how P1 would know when to self-administer this injection every twelve weeks and how P1 would access the injectable medication in P1's support plan addendum.
  
- b. The license holder was assigned responsibility for meeting P1's health needs, including coordinating and facilitating medical appointments, in P1's support plan addendum dated January 9, 2025. The license holder failed to establish P1's primary care physician upon service initiation and this resulted in P1's calcium acetate prescription to lapse. P1 did not receive this medication from March 30, 2025, through April 9, 2025.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- include a description of the procedures the license holder will follow in order to administer P1's PRN psychotropic medication in P1's support plan addendum; and
- document the above-mentioned information P1's support plan addendum regarding P1's injectable medication.

Compliance with this subdivision will be monitored onsite. On an ongoing basis, you must maintain compliance as required in this subdivision.

2. Citation: Minnesota Statutes, section 245D.05, subdivision 2.

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

- a. The license holder was assigned responsibility for medication administration for P1. The license holder failed to implement medication administration procedures to ensure P1 took medications and treatments as prescribed in the following ways:
  - The license holder maintained an incident report for P1 that documented a PRN administration of olanzapine 10mg to P1 on March 31, 2025. The license holder

failed to notate the administration of the medication in P1's medication administration record (MAR) for the above mentioned date.

- The license holder maintained a medication list in an after visit summary for P1, dated April 9, 2025, that stated P1 was prescribed olanzapine, 10mg tablet to be taken at bedtime. The license holder documented in P1's MAR as olanzapine, 10mg one tablet to be taken twice daily for agitation as needed.
- P1 was prescribed the following medications according to the prescriber's medication list dated April 9, 2025:
  - quetiapine 300mg tablet, take ½ tab by mouth in the morning and afternoon.
  - quetiapine 400mg tablet, take one tablet at bedtime.
  - quetiapine 50mg tablet, take two times daily as needed for agitation.
  - Aquafor healing ointment, apply three times daily as needed.
  - Breo Ellipta inhaler, one puff daily.
  - nicotine patch, one patch daily on dry skin as needed.

The license holder did not document these medications in P1's MAR. The license holder failed to ensure P1 took these medications as prescribed.

- P1 was prescribed the following medications according to the prescriber's medication list dated April 9, 2025:
  - risperidone, 2mg tablet, take one tablet every morning.
  - risperidone, 3mg tablet, take one tablet every evening.

The license holder did not document the risperidone 2mg dose in P1's MAR. The license holder documented that P1 was to take risperidone 3mg tablet, two times daily in P1's MAR. Additionally, the license holder documented risperidone .5mg tablet, take one tablet three times daily as needed in P1's MAR. This medication was not on the medication list dated April 9, 2025. The license holder failed to ensure P1 took medications as prescribed.

- P1 was prescribed carbamazepine 200mg tablet, take two tablets two times daily. The license holder documented this in P1's MAR as carbamazepine 200mg, take two tablets two times daily, as well as take one 200mg tablet at 4pm.
- P1 was prescribed docusate sodium 100mg capsule, to be take twice daily at 4pm and 9pm. The license holder documented in P1's MAR that this medication was to be taken at 8am and 8pm.
- P1 was prescribed triphocaps, 1mg capsule, take one tablet every evening with a meal. The license holder documented this on P1's MAR as Reno Cap, take one capsule every evening with food. These are two distinct medications that treat separate vitamin deficiencies. The license holder failed to ensure P1 took medications as prescribed.
- P1 was prescribed senna 8.6mg tablet to be taken once daily. The license holder failed to ensure P1 took this medication as prescribed when the license holder did not document this medication in P1's MAR.

- The license holder documented in P1's MAR that P1 was to take one trazadone 100 mg tablet at bedtime. This medication was not on P1's medication list from the prescriber dated April 9, 2025.
- b. The license holder failed to ensure P1 took medications as prescribed when the license holder failed to implement medication administration procedures. The license holder failed to coordinate refills of P1's medications, resulting in P1 not receiving medications for several days:
- P1 was prescribed atorvastatin, 10mg tablet to be taken daily at 8pm. P1's February MAR documented that the license holder failed to administer the medication from February 10, 2025, through February 12, 2025, due to the license holder's failure to refill the medication.
  - P1 was prescribed Reno Caps, take one capsule daily. P1's February 2025 MAR documented that the license holder failed to administer the medication from February 9, 2025, through February 11, 2025, due to the license holder's failure to refill the medication.
  - P1 was prescribed polyethylene glycol, 17g of powder to mix in 4-8 ounces of water, daily at 8am. The MAR review the license holder completed documented that the license holder failed to administer the medication to P1 on January 14, 2025, through January 16, 2025, due to the license holder's failure to refill the medication.
  - P1 was prescribed lorazepam, 1mg tablet to be taken daily at 8am and 8pm. The license holder maintained a MAR that documented P1 missed several doses of the medication, beginning on January 29, 2025, through February 13, 2025. The license holder failed to administer the medication due to the license holder's failure to refill the medication.
  - P1 was prescribed atorvastatin, 10mg tablet to be taken daily at 8pm. The license holder maintained a MAR that documented P1 missed several does of the medication from February 10, 2025, through February 12, 2025, due to the license holder's failure to refill the medication.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- review P1's prescriber's medication orders and revise P1's MAR to ensure the information on the current prescription label or the prescriber's current order is documented. The information must include the following:
  - person's name;
  - description of the medication or treatment to be provided; and
  - the frequency and other information needed to safely and correctly administer the medication or treatment to ensure effectiveness;
- develop and implement a plan across your program to ensure medication refills are requested in a timely manner to ensure persons receive medications as prescribed when you are assigned the responsibility of medication administration;
- maintain documentation of the plan in your program's records;

- train all staff who are responsible for administering medications on your plan and how to implement it; and
- maintain documentation of the training you provide to staff persons on your plan in the staff persons' personnel records.

Compliance with this subdivision will be monitored onsite. On an ongoing basis, you must maintain compliance as required in this subdivision.

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 and report medication treatment issues as required.

The license holder was assigned responsibility for medication administration for P1. The license holder failed to report P1's failure to take medications to P1's legal representative and case manager as they occurred.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- provide re-training to staff persons who are assigned the responsibility of MAR reviews to ensure the staff persons conduct MAR reviews in compliance with the requirements of 245D.05, subdivision 4;
- maintain documentation of this training in the staff persons' personnel records;
- review P1's MAR to ensure the information maintained in the MAR is current and to identify medication administration errors;
- maintain documentation of the MAR reviews you complete, including the date(s) of completion and the name of the person(s) who completed the MAR reviews;
- report P1's medication errors to their legal representative and case manager; and
- maintain documentation of the notifications regarding the medication errors in P1's record.

Compliance with this subdivision will be monitored onsite. On an ongoing basis, you must maintain compliance as required in this subdivision.

4. Citation: Minnesota Statutes, section 245D.051, subdivision 1.

Violation: For one person whose record was reviewed (P1), the license holder did not monitor the use of psychotropic medications as required.

Target symptoms refer to any perceptible diagnostic criteria for a person's diagnosed mental disorder, as defined by the Diagnostic and Statistical Manual of Mental disorders Fourth Edition Text Revision (DSM-IV-TR) or successive editions, that has been identified for alleviation.

P1 was prescribed multiple psychotropic medications. The license holder failed to document the target symptoms that P1's psychotropic medications were to alleviate.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- document a description of the target symptoms each psychotropic medication is to alleviate for P1; and
- maintain documentation of the target symptoms in P1's support plan addendum.

Compliance with this subdivision will be monitored onsite. On an ongoing basis, you must maintain compliance as required in this subdivision.

5. Citation: Minnesota Statutes, section 245D.11, subdivision 2.

Violation: For one person whose record was reviewed (P1), the license holder did not enforce policies and procedures for safe medication administration as required.

- a. The license holder's medication administration policy stated, "staff will, beginning with the highest number, push the correct dose [from the bubble pack] into a medication cup, and write the date and their initials on the card next to the dose popped out." At the time of the licensing investigation, the DHS licenser observed that the license holder failed to enforce this policy through observation of P1's medications and MAR.
- b. The license holder's medication administration policy stated, "The manager or other assigned staff person will be responsible for checking medication supply routinely to ensure adequate amount for administration." The license holder failed to enforce the program's policy when the license holder failed to check P1's medication supply routinely to ensure an adequate amount for administration (see citation number 2).

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- re-train all staff persons who administer medications on your program's safe medication administration policy;
- maintain documentation of this training in the staff persons' personnel records;
- develop a detailed plan on how the manager or assigned staff person will ensure that the medication supply for all service recipients will be routinely checked to ensure adequate amounts for administration;
- maintain documentation of this plan in your program's records; and
- train the manager or assigned staff person on their responsibilities regarding routine checks of medications.

Compliance with this subdivision will be monitored onsite. On an ongoing basis, you must maintain compliance as required in this subdivision.

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

**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  
ATTN: Legal Unit  
Licensing Division  
PO Box 64242  
St. Paul, MN 55164-0242

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.

Lacey Walsvik, HCBS Human Services Licensor  
Licensing Division  
Office of Inspector General  
651-431-3667