

**MALTREATMENT INVESTIGATION MEMORANDUM**  
**Office of Inspector General, Licensing Division**  
**Public Information**

*Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."*

**Report Number:** 202307071

**Date Issued:** December 20, 2023

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

LSS Prairie  
1710 10th St N  
Moorhead, MN 56560

Lutheran Social Service of Minnesota  
2485 Como Ave  
Saint Paul, MN 55108

**License Number and Program Type:**

1070041-H\_CRS (Home and Community-Based Services-Community Residential Setting)  
1069963-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that there were multiple concerns regarding a vulnerable adult's (VA's) care at the facility. The VA looked disheveled, his/her gums were bleeding, his/her teeth were "caked with grime," there were boils on the VA's back, a sore on the VA's bottom, and dried feces on his/her buttocks.

**Date of Incident(s):** Prior to August 23, 2023

**Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (a):**

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct.

### **Summary of Findings:**

Pertinent information was obtained during a site visit conducted on October 18, 2023; from documentation at the facility and the VA's medical records; and through interviews conducted with facility staff persons (P1, P2, P3, and P4), and a day program staff person (DPS) from a day program where the VA received services. This investigator met the VA, but s/he was unable to provide information regarding the allegations in this report. However, the VA looked neat, clean, and well groomed.

Facility documentation showed that the VA was vulnerable to all forms of maltreatment, and was diagnosed with an intellectual disability, diabetes insipidus, hypernatremia, and seizures. Diabetes insipidus was an incurable disorder that caused the fluids in the body to become out of balance and prompted the body to make large amounts of urine, which affected the VA's body's ability to regulate its sodium levels. Hypernatremia was an electrolyte problem characterized by increased sodium concentration in the blood which might cause lethargy, confusion, and excessive thirst. The VA urinated frequently and wore an adult brief which staff persons were to change every two hours, and s/he had rashes when some types of barrier creams were applied to his/her skin. Persons with diabetes insipidus had feelings of intense thirst even after having something to drink, and usually produced a higher-than-normal amount of urine. Staff persons were to closely monitor and document the VA's salt intake and if the VA was lethargic, had difficulty speaking, or had any changes in behavior, they were to have the VA's sodium level checked.

The VA used a customized wheelchair that was built to fit his/her body for mobility and received liquid nutrition via a feeding tube four times a day but ate one meal a day per mouth, which was usually the evening meal. The VA's physician instructed him/her not to drink liquids by mouth, but s/he received 400 milliliters of water four times a day via the feeding tube following administration of the liquid nutrition. Staff persons were to closely monitor the VA when s/he ate food by mouth and remind him/her to eat slowly because s/he had a history of choking. Staff persons were to assist the VA with all activities of daily living including brushing his/her teeth. The VA received services at a day program facility that provided the VA with activities and skill building services including participating in crafts, games, and exercises, several days a week. The VA usually went to bed at about 8 p.m. on weeknights and by 10 p.m., his/her brief was usually wet. On weekday mornings, the VA was assisted from his/her bed at 6 a.m., assisted to take a shower, and got ready to attend the day program. On the weekends, the VA might sleep later than 6 a.m., but did not remain in his/her bed for extended periods of time unless s/he was ill. The VA was subject to guardianship, had a great smile, and enjoyed spending time with his/her family members.

The VA's verbal communication was limited, but s/he could say yes and no, and point to pictures and letters to answer questions. Asking the VA a question and providing choices worked well when communicating with the VA.

Facility documentation, the VA's medical records, and interviews with this investigator provided the following:

- The DPS said that on August 10, 2023, shortly after the VA arrived at the day program, staff persons there noticed that the absorbent material of the VA's brief burst through the brief and stuck to the VA's skin.

Staff persons removed the material from the VA's skin without any issues and asked the VA whether his/her brief had been changed during the night. The VA said that his/her brief had not been changed and had been wet for many hours. A few days later, the VA developed a boil on his/her left buttock. The VA received medical care for the boil and was absent from the day program for four days. In addition, sometimes when the VA came to the day program, s/he looked disheveled, had feces on his/her buttocks and boils on his/her back, his/her gums bled, and his/her teeth were "caked with grime."

- Boils were painful pus-filled bumps that formed under the skin when bacteria infected or inflamed one or more hair follicles. Boils usually began as red or purple, tender bumps, that quickly filled with pus over a few days, and grew larger and more painful until they ruptured and drained. Areas most likely to have boils included the face, back of the neck, armpits, thighs, and buttocks. Small single boils usually did not require the care of a physician, but medical assistance should be sought if a boil occurred on the face or affected the vision, worsened rapidly or was extremely painful, caused a fever, got bigger despite self-care, did not heal in two weeks, or recurred.
- Documentation at the facility showed that staff persons took the VA to appointments at his/her endocrinologist's office every two weeks. On July 18, 2023, staff persons also took the VA to a dental cleaning, to an appointment with his/primary care physician on August 14, 2023, for a possible boil on his/her bottom, and to a dermatologist on August 23, 2023, to check moles and "spots" on his/her back. The medical appointments were confirmed by the VA's records.
- The VA's medical records showed that on August 14, 2023, the VA was evaluated at the emergency department of a hospital for a reddened, eight-centimeter abscess of the left buttock that was a "new problem" that started more than two days prior and was gradually worsening. There was also a rash on the VA's left buttock. The abscess was incised and drained using local anesthetic and had a moderate amount of purulent/bloody drainage. A drain was placed in the abscess, and it was packed with gauze that was saturated with antimicrobial medication. The VA's vital signs were within normal limits, and s/he had no fever. The discharge instructions from the hospital showed that the gauze should be removed in two days and the abscess should then be covered with an adhesive bandage. The VA was prescribed Bactrim and discharged back to the facility but was to return to the hospital if s/he had a fever or worsening symptoms. On August 23, 2023, the VA was evaluated by a dermatologist for three moles on his/her back. Two of the moles were benign and one was removed for biopsy, but no information in the medical records showed the outcome of the biopsy. Staff persons were to monitor the site of the mole and follow up with a medical professional if pigmentation re-occurred in the area. No information in the medical records described lumps on the VA's back and nothing showed that there were complications or return visits for further treatment of the abscess or the moles.
- P1 and P2, who were supervisory staff persons at the facility, provided consistent information that there was ongoing conflict between the facility and some members of the VA's care team regarding the facility's delivery of "person-centered" services. There was discussion between the facility and the team about services that were important to and important for the VA, and when it was wise for the VA to make decisions about the way in which services were provided to him/her. It was thought that there was a misunderstanding of the facility's efforts to advocate for the VA when facility staff persons told the VA that s/he did not have to participate in or complete goals if s/he did not want to. Some members of the team thought that staff persons told the VA that s/he did not have to follow his/her plans when it might

have been in the VA's best interests to do so. The VA's team wanted the VA to be assisted to take a shower daily, but the VA preferred to take a shower every two to three days, which caused disagreement among the team members.

- In addition, concerns arose within the team when some staff persons communicated with each other using a language other than English. P1 said that staff persons occasionally spoke the other language because there was an individual who actively listened to staff persons' conversations, and they were trying to prevent the individual from obtaining information about other facility residents. Staff persons attempted to have all conversations about individuals in the facility office with the door closed and used a white noise machine to prevent anyone from overhearing their conversations. The individual who listened to conversations then sat outside the office door to better hear the conversations and used a translating app on his/her mobile phone to translate conversations held in the other language to English. The individual also provided information about the VA and his/her care to the VA's team, but some of the information was not accurate and the individual's actions were an ongoing issue at the facility.
- Information was consistent from P1, P2, P3, and P4, that the VA was assisted from his/her bed each morning, his/her brief was changed, s/he was assisted to take a shower and groom him/herself, and assisted to brush his/her teeth. Staff persons then helped the VA choose and put on clean clothing and get ready to go to the day program. P3 and P4 were seasoned staff persons who had worked with the VA for a couple of years and P4 said that staff persons placed a protective cloth on the VA when s/he ate snacks or meals because the VA might spill or drop food, or produce excess saliva, which could fall onto his/her clothing. Staff persons worked diligently to keep the VA and his/her clothing clean, but it was difficult to do. The facility used the resources it had to take care of the VA, and staff persons were told to use as many wipes/briefs as needed to keep the VA clean and dry. The VA produced excess urine and might soil his/her brief between after leaving the facility but before arriving at the day program. However, staff persons did not knowingly send the VA to the day program in dirty clothing, with feces on his/her bottom, or soiled briefs.
- P1 stated that s/he was previously unaware of the abscess on the VA's buttock until the DSP brought it to the facility's attention and there was no documentation regarding the abscess until staff persons took the VA to the hospital on August 14, 2023. P3 said that s/he thought that the abscess was part of a rash on the VA's bottom and applied a cream to it. P4 said that the abscess on the VA's bottom initially was red and looked like a "pimple," but did not look concerning. When the facility became aware that it was an abscess, care was immediately sought for the VA. *T-logs* (progress notes) for the VA, showed that s/he might decline to take a shower or complete other hygiene tasks even when assistance was offered to him/her multiple times. Brief changes were not always documented in the *T-logs*, but information was consistent from P1, P2, P3, and P4 that the VA's brief was to be changed every two hours or sooner if the VA requested it or staff persons noticed that the brief was wet. The VA's briefs were changed in the VA's bed, because the VA needed to lie down during the process, and two to three staff persons were needed for brief changes because the VA was unable to assist staff persons during the change by rolling onto his/her side or holding him/herself on his/her side by holding the rails on his/her bed.
- P1 thought that it would be painful for the VA to sit in the wheelchair on his/her bottom at the day program while the abscess healed. The VA did not go to the day program for a few days so that facility staff persons could move him/her between his/her bed, recliner, and wheelchair and reposition him/her

every two hours or more often if needed, which prevented consistent pressure on the VA's bottom. However, the VA got upset each time s/he was moved/repositioned, because s/he did not like to be repeatedly shifted and might call staff persons "losers" or hit his/her head. If the VA became upset, staff persons were to reassure the VA that they were trying to help him/her. Before the VA returned to the day program, s/he was evaluated by a community health care professional to ensure the abscess was healed enough to return. After the abscess was treated, staff persons began documenting the VA's brief changes and assistance with hygiene matters more often.

- P1 said that staff persons assisted the VA to brush his/her teeth in the morning and in the evening, but food might stay on the VA's teeth because s/he could not have fluids by mouth. Staff persons assisted the VA to rinse his/her mouth with water, then spit the water out because the VA was not to have liquids by mouth. The facility bought an extra toothbrush and additional toothpaste, then sent them with the VA to the day program. When the VA did not want staff persons to assist him/her to brush his/her teeth, s/he might bite down on the toothbrush in his/her mouth to prevent staff persons from moving the brush or hit his/her head with his/her hand. The facility had asked the team about using glycerin swabs to moisten the VA's mouth at one of the team meetings but did not get an answer, and no information showed that VA had bleeding gums at the facility. The VA's physician prescribed absorbent inserts to place inside the VA's briefs, and the facility purchased some, but the inserts were expensive and not covered by the VA's insurance. The VA's team discussed the responsibility for purchasing the inserts, but a decision was not reached.
- According to P1, the VA had "lumps" on his/her upper back that were there when P1 began working at the facility several years ago, but the lumps had not changed in shape or size during that time, and there were no previous concerns about them. The VA had a degenerative spine issue that had recently caused changes to the shape of the VA's body and causing the VA to slide out of his/her wheelchair. The VA's team obtained a new wheelchair back for the VA, but there were concerns that the VA's spine would continue to change over time and his/her health would worsen. There were three staff persons on each day shift and two awake staff persons per overnight shift to provide care to the VA and the three other individuals who resided at the facility.

Personnel files showed that the facility trained its staff persons on the Reporting of Maltreatment of Vulnerable Adults Act, the facility's policies and procedures, and the VA's plans of care prior to August of 2023.

### Conclusion:

The DSP said that on August 10, 2023, when the VA came to the day program, his/her adult brief had burst, causing the material in the brief to stick to the VA's skin. The VA told day program staff persons that his/her brief was not changed timely and had been wet for many hours. The VA developed a boil on his/her buttock a few days later. In addition, the VA had boils on his/her back, and sometimes looked disheveled, and had feces on his/her bottom, bleeding gums, and dirty teeth when s/he came to the day program.

The VA's medical records showed that on August 14, 2023, the VA had a red, eight-centimeter abscess and a rash on the left buttock. The abscess was cleared of purulent/bloody discharge and packed with medicated gauze, which was to be removed after two days. The VA's vital signs were within normal limits, and s/he was to seek further medical care if s/he had a fever or worsening symptoms. On August 23, 2023, the VA was evaluated for

three moles on his/her back, two of which were benign. The third mole was removed and biopsied, but the outcome of the biopsy was unknown. Staff persons were to monitor the site of the mole that was removed.

Information was consistent from P1 and P2 that there was ongoing conflict between the facility and members of the VA's team regarding person centered services for the VA and staff persons who communicated with each other in a language other than English. However, the other language was used to prevent an individual at the facility from obtaining information about other facility residents and a white noise machine to prevent anyone from listening to conversations.

P1, P2, P3, and P4 each said that the VA's briefs were changed every two hours or more often when staff persons became aware that they were soiled. The VA urinated frequently, and staff persons were told to use the supplies that were necessary to care for him/her. The VA was assisted to take a shower, to groom him/herself, and to brush his/her teeth daily. The VA's clothing might get soiled before s/he arrived at the day program if excess saliva or snacks fell onto it, and s/he might urinate or defecate in his/her brief on the ride to the day program.

P1 said that s/he was unaware that the VA had an abscess on his/her buttock until the day program told the facility about it on August 14, 2023, P3 thought it was part of a rash, and P4 thought the abscess was a pimple, but it did not look concerning. The facility got medical care for the abscess the same day the day program notified them of it, and medical records showed that the abscess was treated, and staff persons were instructed to bring the VA back to the hospital if s/he had a fever or worsening symptoms. On August 23, 2023, the VA was evaluated for three moles on his/her back. Two moles were benign, one mole was removed and biopsied, and staff persons were given follow up instructions. No information showed that the VA had complications or issues from the abscess or moles, and nothing in the medical records described lumps on the VA's back.

*Regarding hygiene:*

Although the VA might have been disheveled, had bleeding gums, teeth that were caked with grime, and dried feces on his/her buttocks at the day program, given that information was consistent that the VA was assisted with hygiene and oral care daily at the facility, that staff persons provided consistent information that the VA's briefs were changed as required, and that the VA's diagnoses included a condition that caused him/her to produce higher than normal amounts of urine, there was not a preponderance of the evidence whether there was a failure to provide the VA with care that was reasonable and necessary to obtain or maintain the VA's health or safety.

*Regarding the abscess and the moles:*

Although the VA had an abscess on his/her bottom and the DPS said that the VA had lumps on his/her back, given that some staff persons were unaware of the abscess, P3 thought the abscess was part of rash and P4 thought it was a pimple, that the facility got medical care for the abscess the same day it was made aware of it, that P1 said the lumps on the VA's back had been present for several years, but exhibited no changes, and that the facility took the VA for a prompt evaluation of the skin on his/her back when concerns were raised, there was not a preponderance of the evidence whether there was a failure to provide the VA with health care that was reasonable and necessary to obtain or maintain the VA's health or safety.

It was not determined whether neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is

reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

**Action Taken by Facility:**

The facility completed an *Internal Review* which determined that its policies and procedures were adequate and were followed.

**Action Taken by Department of Human Services, Office of Inspector General:**

No further action taken.