

**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:** 202400202

**Date Issued:** March 8, 2024

**Name and Address of Facility Investigated:**

Ubbah Omer Adult Foster Care/HCBS  
7586 Inland Lane N  
Maple Grove, MN 55311

**Disposition:**

**Allegation One:** Inconclusive  
**Allegation Two:** Inconclusive  
**Allegation Three:** False

**License Number and Program Type:**

1108112-AFC (Adult Foster Care)  
1085095-HCBS (Home and Community-Based Services)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

**Allegation One:** It was reported that a vulnerable adult (VA) was not getting proper assistance with his/her hygiene.

**Allegation Two:** It was reported that the VA sustained pressure sores on his/her buttocks from either sitting too long on the toilet or sitting in his/her feces and urine.

**Allegation Three:** It was report that the VA did not receive laxatives.

**Date of Incident(s):** ongoing prior to January 6, 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 January 30, 2023; from documentation at the facility and medical records; and through seven interviews conducted with a facility staff person (SP), a staff person from the VA's new facility (P), the VA's guardians (G1-G3), the licensor who oversaw the VA's AFC license (L), and a community person (CP) who worked where the VA attended school.

The VA was diagnosed with a mild developmental disability and autism and the VA did not verbally communicate. Consistent information was provided that the VA wore adult undergarments at night.

The L stated that on November 30, 2023, the SP emailed the L that s/he was giving the VA and the other clients a 60-day notice of closing. On January 23, 2024, the SP told the L s/he wanted to still end the AFC license but wanted to possibly pursue another license at the same location. The L did not have concerns with the facility.

Consistent information was provided that the VA moved out of the facility on January 6, 2024, because of the notice of closing.

Facility documentation showed that staff persons, including the SP, were trained on the VA's plans and the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident.

**Allegation One:** *It was reported that the VA was not getting proper assistance with his/her hygiene.*

According to the VA's *Intensive Support Self-Management Assessment*:

- The VA needed physical assistance with showers, including adjusting water temperatures. Staff persons provided physical assistance with regulating water temperature to shower and wash his/her hands.
- The VA needed assistance with fingernail cutting and other grooming. Staff persons provided verbal and hands on assistance with the VA's grooming.

G1-G3 provided the following information:

- G2 stated that in October or early November of 2023, the VA's hygiene started to decline, including that the VA's clothes were not washed and the VA had not showered.
- On one occasion, G2 emailed or texted the SP asking to make sure that the VA showered prior to him/her visiting them.
- G1, G2, and G3 saw the VA early in December on an unknown date and did not notice any concerns with the VA's hygiene other than needing his/her fingernails trimmed.
- On December 24, 2023, the VA came to visit and "stunk" so G1 and G2 "immediately" had the VA shower. The VA's hair had not been washed, the VA smelled of body odor, and his/her fingernails were dirty. The VA's clothes were wrinkled and looked like they had been lying in a pile on a floor. G1 and G2 did not assist the VA with the shower or see his/her buttocks during that time. The VA returned to the facility on December 25, 2023, and G1 and G2 did not mention their concerns with the VA's hygiene to the SP.

- On December 30, 2023, G1 brought the VA to meet the P and tour the new facility. G1 was not near the VA and was not with him/her "long" so G1 was not able to provide information on the VA's hygiene other than the VA's hair was "disheveled."

The SP provided the following information:

- The SP had a staff person who came to the facility in the afternoons otherwise the SP provided the VA and other clients with their cares.
- When the VA moved into the facility, G1 and G2 "insist[ed]" that the VA showered on his/her own. G1 and G2 told the SP to provide the VA with soap and verbally prompt the VA to wash his/her body. The VA dried him/herself off after a shower. The VA showered every morning and the SP did not document the VA's showers.

The CP was new to the VA's school but reviewed notes made by other staff persons. On one occasion, another community person contacted the facility and requested that the VA's fingernails were cut and the following day the VA came back to school with his/her nails cut. There were no other hygiene concerns.

#### **Conclusion Allegation One:**

G1-G3 provided consistent information that there were concerns with the VA's grooming, including showering. Although there were occasions when the VA's hair had not been washed, the VA smelled of body odor, and his/her fingernails were dirty; given that the VA's plans stated that staff persons provided assistance with water temperature for showers and hand washing and provided "verbal and hands on" assistance with the VA's grooming; that the SP, G1, and G2 each stated that the VA showered on his/her own; that the CP did not have concerns regarding the VA's hygiene; and there was no information provided that the SP did not follow the VA's plans with showering, there was not a preponderance of the evidence whether there was a failure to provide reasonable and necessary care to the VA.

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).

*Allegation Two: It was reported that the VA sustained pressure sores on his/her buttocks from either sitting too long on the toilet or sitting in his/her feces and urine.*

According to the VA's *Intensive Support Self-Management Assessment*, the VA had an increase in urine incontinence at night and the VA wore adult undergarments to bed. The VA did not initiate asking for assistance with clean up when incontinent. Staff persons monitored the VA for incontinence and assisted with "ensuring proper hygiene as needed." Staff persons also encouraged routine bathroom visits during the day.

According to the VA's medical records, on January 10, 2024, the VA was diagnosed with "skin breakdown due to an irritant/contact dermatitis, possibly prolonged or recurrent contact with urine or stool." The VA was prescribed mupirocin ointment that was applied three times daily for one week. A triple paste ointment was recommended for between applications of the mupirocin ointment. The VA was also prescribed cephalixin (antibiotic) but no additional information was provided for it.

G1 and G2 provided the following information:

- The VA did not require assistance while toileting except verbal prompts so the VA limited his/her time sitting on the toilet. In the mornings, the VA lay in bed until s/he was verbally prompted to use the toilet and then independently used the toilet and removed his/her adult undergarment. The VA "rarely" was incontinent with feces but was more so with urine.
- When the VA was visiting G1 during the overnight of December 24, 2023, G1 and G2 did not assist the VA with his/her adult undergarment, toileting, or showering so G1 did not see the VA's buttocks. The VA had been incontinent during that night but changed his/her adult undergarment after being verbally prompted.
- On December 30, 2023, G1 did not assist the VA with toileting or see his/her buttocks.
- On January 6, 2023, G1 picked up the VA from the facility and helped the VA with moving into the new facility. The VA smelled like body odor but G1 did not see the VA's buttocks at that time.
- On January 7, 2023, G1 received a phone call from the P saying that s/he noticed "some bruising and soreness" on the VA's buttocks.
- On January 8, 2024, G2 received a phone call from the CP. The CP said that the VA had sores on his/her buttocks that appeared "painful and uncomfortable." G2 asked the CP how long s/he thought the sores had been there and the CP could not say but it appeared to have been a prolonged amount of time.
- On January 9, 2024, the CP called G2 and said that the sores opened and recommended a medical appointment. G2 called and scheduled a medical appointment for January 10, 2024.
- On January 10, 2024, G1 brought the VA to a medical appointment. The VA had bruising on his/her lower buttocks and upper thighs due to sitting on the toilet for long periods of time. The VA also had two open wounds on his/her buttocks that were the size of a half dollar each. The doctor said it appeared that the VA had been lying in urine and/or feces in his/her adult undergarment "for a while" and must have happened "over time" instead of just one night. The VA did not have sores or bruising on the front side so the doctor said the sores and bruises occurred when the VA was lying down. The doctor had a second doctor come in and assess the VA's injuries and that doctor also said the sores and bruising occurred when the VA was lying down. The VA received a prescription ointment to apply to the wounds until they healed.

The CP stated on January 9, 2024, the VA "complained" of pain with his/her buttocks. The CP brought the VA into the bathroom and saw "open blisters" and skin "peeled off" the VA's buttocks. The CP "gently" cleaned the sores and then called G2. The CP explained the sores to G2 and texted G2 a picture of them. G2 said s/he would bring the VA to a medical appointment and afterwards, the CP applied ointment and ensured the VA was comfortable sitting at school. The sores possibly could have been caused from the VA sitting in a wet adult undergarment on multiple occasions. The CP denied seeing bruising on the VA's buttocks. There were no other concerns documented.

Photos taken by the CP showed two open sores on the VA's buttocks.

The P stated that on January 6, 2023, when the VA moved into the new facility, the P was not told that the VA was incontinent during the night. On January 7, 2023, when the P woke up the VA and assisted him/her with toileting, the P saw that the VA had been incontinent with urine and feces during the night so the P assisted the VA with a shower. The P saw a sore on the VA's buttock that could not have occurred in a single night or the prior night. The P checked the VA's bedding and everything was "wet." The VA went to school and the P notified G1 and G2 about the sores. The VA wore adult undergarments to bed and was incontinent with urine every night and with

bowel movements every two to three nights so the P assisted the VA with a shower every morning to clean the VA's skin and then apply the prescribed ointment.

The SP stated that the VA needed verbal prompts to use the toilet during the day otherwise s/he was incontinent. Every night before bed, the SP reminded the VA to use the toilet and "sometimes" in the middle of the night. When the VA woke up, s/he stayed in bed and made noises, such as singing. The SP went into the VA's bedroom and verbally prompted the VA to use the toilet. The SP reminded the VA through the bathroom door about getting off the toilet, assisted the VA with throwing away the adult undergarment, and verbally reminded the VA to shower. There were some occasions when the VA had been incontinent with feces during the night. The SP did not provide assistance with toileting, such as wiping. The VA showered "every morning." If the VA's bedding was wet, the SP washed it. The SP did not notice anything unusual with the VA when s/he resided at the facility and was unaware that the VA had sores and/or bruising on his/her buttocks in part because the VA was independent using the toilet and shower.

### **Conclusion Allegation Two:**

Consistent information was provided by G1, G2, the P, and the SP that the VA wore adult undergarments at night due to incontinence. The P stated on January 7, 2024, in the morning when assisting the VA with cleaning after incontinence, the P saw a sore on the VA's buttock that could not have occurred the prior night or in a single night.

The CP and photos showed that on January 9, 2024, the CP brought the VA into the bathroom and saw "open blisters" and skin "peeled off" the VA's buttocks. The VA was brought to a doctor and was diagnosed "skin breakdown due to an irritant/contact dermatitis, possibly prolonged or recurrent contact with urine or stool."

Although the VA had sores and possible bruising on his/her buttocks which a doctor said was likely due to exposure of feces and/or urine over a period of time or sitting on the toilet for a long time, given that the VA was independent with using the bathroom and shower with verbal prompts; that G1, G2, and the SP stated that they verbally reminded the VA to use the toilet and shower; and that the SP did not provide assistance with wiping, toileting, or showering the VA; there was not a preponderance of the evidence whether there was a failure or omission to provide reasonable and necessary care to the VA.

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).

**Allegation Three:** *It was reported that the VA did not receive laxatives.*

According to the VA's *Intensive Support Self-Management Assessment*, the VA needed assistance with medication administration. Staff persons assisted the VA with medication refills, administration, and treatment orders.

G1 stated s/he previously bought the VA Miralax (laxative to prevent constipation) and brought the unopened container to the facility. G1 told the SP to put some in the VA's water every day to help him/her with bowel movements. The Miralax was doctor recommended, not prescribed. On January 6, 2024, when G1 went to the facility and packed the VA's things, s/he saw that the bottle of Miralax was still unopened so it had not been used. G1 did not have concerns with the VA's other medications.

The P stated that when the VA moved into the new facility, G1 provided the P with an edible "chocolate laxative" to take once per day usually with lunch or dinner.

The SP stated that the VA took a chocolate laxative every night, which is why s/he was able to have bowel

movements during the night. G1 provided a box of Miralax for as needed with the VA but the SP did not give the VA any since the VA had bowel movements daily with the chocolate laxative.

According to the VA's *Medication Administration Record (MAR)*, from January 1, 2023, to January 5, 2024, the VA was given 15 milligram (half of one side) of "chocolate laxative" in the evening.

**Conclusion Allegation Three:**

G1 stated s/he bought the VA Miralax, which was doctor recommended, and brought the unopened container to the facility. On January 6, 2023, when moving the VA, G1 found an unopened container of Miralax.

Given that the SP stated and documentation showed that the SP provided the VA with the chocolate laxative and the VA had bowel movements and that the Miralax was recommended but not prescribed by a doctor, and that there was no information provided that the VA had any issues with his/her bowel movements while taking the chocolate laxative, there was a preponderance of the evidence that there was not a failure to provide reasonable and necessary care to the VA.

It was determined that neglect did not occur (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* and determined that policies and procedures were adequate and followed. The facility implemented daily log notes showing what cares were provided to each client.

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

No further action taken at this time.