

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

*Minnesota Statutes, section 260E.01, paragraph (a), "The legislature hereby declares that the public policy of this state is to protect children whose health or welfare may be jeopardized through maltreatment."*

**Report Number:** 202406881

**Date Issued:** May 28, 2025

**Name and Address of Facility Investigated:**

Bar None Residential Services  
22426 Saint Francis Boulevard  
Anoka, MN 55303

**Disposition:** Maltreatment determined as to neglect of an alleged victim by two staff persons.

**License Number and Program Type:**

1036848-CRF (Children's Residential Facility)

**Investigator(s):**

Kim Anderson/Beth Virden  
Minnesota Department of Human Services  
Office of Inspector General, Licensing Division  
PO Box 64242  
Saint Paul, Minnesota 55164-0242  
kimberly.huett.anderson@state.mn.us  
651-431-6553

**Suspected Maltreatment Reported:**

It was reported that staff bought chemical hair removal cream for an alleged victim (AV), which caused a chemical burn under the AV's arms.

**Date of Incident(s):** August 6, 2024

**Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 260E.03, subdivision 15, paragraph (a), clauses (1) and (2):**

Failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so.

Failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so.

**Summary of Findings:**

Pertinent information was obtained during a site visit conducted on September 9, 2024; from documentation at the facility; and through seven interviews conducted with the AV, the AV's family member (FM), facility staff persons (SP1 and SP2), supervisory staff persons (P1 and P2), and a facility nurse (P3).

A *Diagnostic Assessment* stated that in June 2024, the AV moved into the facility seeking residential treatment for "emotional and behavioral concerns." The facility provided therapy, psychiatry, and daily programming. The AV was 16 years old.

The facility was a locked building with multiple staff providing mental health services to youth ages 11 to 17.

The facility's *Incident Report*, dated August 6, 2024, stated the following:

At around 6:50 p.m., [the AV] requested to take a shower and use [chemical hair removal cream] that [SP1] bought for them that day. Staff allowed [the AV] to use cream under supervision, telling them they had to be in eyesight while using the cream. [SP2] set a timer for [the AV] so they could notify them when it was time to wipe it off. [The AV] began to wipe cream off, and asked for staff assistance from [SP1] due to [the AV's] armpits burning and itching. [SP2] immediately called [P3], in which [SP2] was told to get the remainder of the cream off and treat it with Vaseline (over-the-counter skin protectant/petroleum jelly). [SP2] rinsed the area, let it air dry, and applied Vaseline.

On the morning of August 7, 2024, at an unspecified time, staff photographed the AV's left underarm and provided a copy for this investigation. A red circle stretched beyond the underarm area with flaking skin and streaks of darker red in the skin creases. A measuring device was not included. [Note: Information was provided that both of the AV's underarms had similar symptoms. The AV's right underarm was not photographed.]

The AV provided the following information:

- The AV saved up his/her "bar none bucks," which were a facility perk for youth to get extra snacks. When a youth reached 100 bar none bucks, they could ask staff to do a store run for specific items. The AV saved up to 100 and asked staff to buy him/her chemical hair removal cream. The AV had never used chemical hair removal cream before but wanted an alternative to shaving.
- SP1 bought the cream and gave it to the AV.
- The AV did not test if s/he was allergic to the cream prior to applying. Instead, the AV immediately applied the cream to his/her legs. The cream remained for ten minutes and then the AV wiped it off. The AV's leg hair was removed without issue. The AV then applied the cream to his/her underarms. However, within a few minutes, both of the AV's underarms were "burning." The AV wiped the cream off and his/her underarms hurt "really bad" and were bleeding.
- SP1 and SP2 were both aware the AV was using the hair removal cream and/or were present, supervising the AV during the process.

- The AV believed the hair removal cream was on his/her underarms for ten minutes but the burning sensation started before that. Once the cream was removed, SP1 or SP2 applied ointment to the AV's underarms. It took a few weeks for the AV's underarms to fully heal. The healing process was "really bad" and "hurt."

The FM said that the staff did not ask his/her permission for the AV to use chemical hair removal cream. If they had asked, the FM would have said, "No," because of the AV's family history with "extremely sensitive" skin. The cream caused the AV's underarms to "peel" and "blister."

The facility's *Internal Review*, SP1, SP2, P1, P2, and P3 provided the following information:

- SP1 said that on an unspecified date, the AV gave him/her a list of items to buy at the store using his/her 100 bar none bucks; the list included brownie mix and chemical hair removal cream. SP1 bought the items and told P1 about the items s/he purchased, including the hair removal cream. According to SP1, P1 saw the hair removal cream and said that it was "fine." SP1 then gave it to the AV. [Note: The hair removal cream was put in the AV's shower caddy, which was kept at the staff desk.]
- SP2 said that on an unspecified date and time, s/he watched the AV, in the living room, apply the hair removal cream under both of his/her arms. SP2 set a timer to remove the cream per the packaging instructions. When the timer alarmed, the AV went into the bathroom to wipe the cream off but soon came out "in pain and frantic." SP2 saw that both of the AV's underarms had "red skin peeling off in layers ... a little bleeding ... very raw."
- The facility's *Internal Review* stated that SP2 said the timer was set for ten minutes. According to the facility's camera system, the AV applied the cream at 6:49 p.m. and at 6:51 p.m., SP2 helped wipe it off of the AV's underarms.
- SP1 saw that the AV's underarms had "a good layer or two (of skin) burned off. There was a "decent amount of peeling and speckled tiny bit of blood." "Very raw."
- SP1 and SP2 each said that SP2 called P3 and told him/her that the skin was raw, peeling, and bleeding.
- P3 recalled this phone call and said that SP2 told him/her the AV's underarms were "red." SP2 did not say anything about the AV's underarms bleeding. P3 determined the AV sustained a "mild chemical burn" from the hair removal cream, which did not require urgent care. P3 told SP2 to offer the AV over-the-counter pain reliever, Vaseline, and/or ice but the AV "refused all treatment" from P3. The next morning, August 7, 2024, staff sent a picture of the AV's left underarm (described above). P3 called the facility's medical director who agreed that the AV did not need to be seen in urgent care. The doctor wrote an order for Desitin Ointment (rash cream/skin protectant) as needed for a "chemical burn" under the AV's arms. Staff picked up the Desitin that same day and began applying to the AV's underarms right away. P3 never saw the AV's underarms in-person. P3 did not have concerns with how the incident was handled by staff or the doctor's treatment plan. [Note: Desitin is available as an over-the-counter product.]
- P1 and P2 each said that chemical hair removal cream was prohibited at the facility and was listed as being prohibited in the staff orientation training documents. P1 said that SP1 did not say anything to him/her about the hair removal cream prior to giving to the AV and that s/he learned of it after the

incident.

- SP1 said that s/he read through the list of prohibited items in the staff orientation training documents but did not notice the prohibition of chemical hair remover and said that it was an “absent of mind on my part.”
- SP2 said that when SP1 bought the chemical hair remover, SP2 “didn’t think anything of it. I trusted it ... I didn’t know it was prohibited. Had no idea.”

The facility’s *Program Handbook*, dated May 2024, stated that residents on “phase 2” of programming may use a razor to shave during hygiene time. “No chemical hair removal products can be used.”

According to the packaging of the chemical hair removal cream used by the AV:

WARNINGS: IRRITATION OR ALLERGIC REACTION MAY OCCUR WITH SOME PEOPLE, EVEN AFTER PRIOR USE WITHOUT ADVERSE EFFECT. THEREFORE, TEST BEFORE EACH USE BY APPLYING PRODUCT TO A SMALL PART OF THE AREA WHERE HAIR IS TO BE REMOVED. FOLLOW DIRECTIONS AND WAIT 24 HOURS. IF SKIN APPEARS NORMAL, PROCEED WITH FULL APPLICATION. DO NOT USE ON IRRITATED, SUNBURNED, INFLAMED, OR BROKEN SKIN. KEEP AWAY FROM EYES. SHOULD PRODUCT TOUCH THE EYES, WASH THOROUGHLY WITH LUKEWARM WATER. IF IRRITATION OCCURS, DISCONTINUE USE. IF IRRITATION PERSISTS, CONSULT YOUR PHYSICIAN. DO NOT USE ON FACE, AROUND EYES, IN NOSE, IN EARS, OR ON BREAST NIPPLES, PERIANAL, OR VAGINAL/GENITAL AREAS. KEEP OUT OF REACH OF CHILDREN.  
(emphasis in original)

According to healthline.com:

[Chemical hair removal creams] can burn your skin, even if you use them as intended ... There are remedies and over-the-counter methods to treat depilatory (hair removal) burns at home ... See a doctor if your burn appears to be getting worse. If your blisters start to ooze pus or turn yellow, you should see a doctor immediately as this could be a sign of a more serious infection.

Facility documentation stated that SP1, SP2, P1, P2, and P3 received training on the facility’s *Program Handbook* and the Reporting of Maltreatment of Minors Act. P3 was not required to receive training on the facility’s *Program Handbook*.

### **Conclusion:**

#### **A. Maltreatment:**

The AV, the FM, SP1, SP2, and P1-P3 provided consistent information that at the AV’s request, SP1 bought chemical hair removal cream for the AV and the AV applied it under his/her arms while supervised by SP1 and SP2 and sustained a chemical burn. SP2 called P3, who advised that the AV did not need urgent care and could be treated at the facility with over-the-counter pain reliever, Vaseline, and ice. A doctor was contacted the next morning, who ordered as needed Desitin cream. The AV said that his/her underarms took a few weeks to fully heal and was “really bad” and “hurt.”

The AV was living at the facility to receive residential treatment for “emotional and behavioral concerns.” The AV was 16 years old and relied on staff to provide his/her care and supervision at the facility. The *Program Handbook*, dated May 2024, stated, “No chemical hair removal products can be used.”

Given that SP1 purchased and provided to the AV a chemical hair removal product which was prohibited by the facility, that SP1 and SP2 then supervised the AV using the prohibited item, that SP1 and SP2 failed to follow the instructions that stated, “TEST BEFORE EACH USE BY APPLYING PRODUCT TO A SMALL PART OF THE AREA WHERE HAIR IS TO BE REMOVED. FOLLOW DIRECTIONS AND WAIT 24 HOURS. IF SKIN APPEARS NORMAL, PROCEED WITH FULL APPLICATION,” and that the AV sustained an injury directly relating to his/her use of the chemical hair removal product, there was a preponderance of the evidence that there was a failure by staff to supply the AV with necessary care required for the AV’s physical or mental health when reasonably able to do so and a failure to protect the AV from conditions or actions that seriously endangered the AV’s physical health when reasonably able to do so.

It was determined that neglect occurred (failure by a person responsible for a child’s care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child’s physical or mental health when reasonably able to do so. Failure to protect a child from conditions or actions that seriously endanger the child’s physical or mental health when reasonably able to do so).

B. Responsibility pursuant to Minnesota Statutes, section 260E.30, subdivision 4, paragraph (a), clauses (1) and (2):

When determining whether the facility or individual is the responsible party, or whether both the facility and the individual are responsible for determined maltreatment in a facility, the investigating agency shall consider at least the following mitigating factors:

- (1) whether the actions of the facility or the individual caregivers were according to, and followed the terms of, an erroneous physician order, prescription, individual care plan, or directive; however, this is not a mitigating factor when the facility or caregiver was responsible for the issuance of the erroneous order, prescription, individual care plan, or directive or knew or should have known of the errors and took no reasonable measures to correct the defect before administering care;
- (2) comparative responsibility between the facility, other caregivers, and requirements placed upon an employee, including the facility’s compliance with related regulatory standards and the adequacy of facility policies and procedures, facility training, an individual’s participation in the training, the caregiver’s supervision, and facility staffing levels and the scope of the individual employee’s authority and discretion; and
- (3) whether the facility or individual followed professional standards in exercising professional judgment.

SP1 and SP2 were responsible for the AV’s care and supervision. Although SP1 said that s/he did not recall hair removal cream being listed as a prohibited item and SP2 said that s/he did not know hair removal cream was prohibited, SP1 and SP2 each received training on the facility’s *Program Handbook* which stated, “No chemical

hair removal products can be used." SP1 and SP2 were also trained on the Reporting of Maltreatment of Minors Act.

SP1 purchased the chemical hair removal cream which was a prohibited item and gave it to the AV. SP1 and SP2 then each supervised and allowed the AV to use the prohibited item in addition to not ensuring that the directions were followed.

SP1 and SP2 were each responsible for maltreatment of the AV.

#### C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services.

Minnesota Statutes, section 245C.02, subdivision 16, states:

"Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

"Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated neglect for which SP1 and SP2 were responsible did not meet statutory criteria to be determined as recurring or serious. Although the AV sustained a chemical burn under her arms, it was treated with over-the-counter products and did not require the care of a physician whether or not the care of the physician was sought.

Pursuant to Minnesota Statutes, section 260E.35, subdivision 6, paragraph (c) all investigative data maintained in this report will be kept by the Department of Human Services for at least ten years after the date of the final entry in the report.

**Action Taken by Facility:**

The facility completed an internal review and determined that policies and procedures were adequate but not followed. The facility retrained the staff involved "on practices in the handbook, specific to health and hygiene and rules regarding shaving and the use of chemical products." The staff involved and/or the AV were not part of any similar, past events.

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

SP1 and SP2 were not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 and SP2 were notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of SP1 and/or SP2. The determination that SP1 and SP2 were responsible for maltreatment is subject to appeal.

**Certification:**

The information collection procedures followed in this investigation were pursuant to Minnesota Statutes, section 260E.30, subdivision 6, paragraph (c). All individuals that are subjects of data in this investigation have the right to obtain private data on themselves which was collected, created, or maintained by the Department of Human Services.