

**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:** 202505292

**Date Issued:** November 6, 2025

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

Moshood Olawale Alabede – Adult Foster Care  
1332 32nd Street Circle South  
Moorhead, MN 56560

Prince Foster Care - Adult Foster Care  
1332 32nd Street Circle South  
Moorhead, MN 56560

**License Number and Program Type:**

1099874-AFC (Adult Foster Care)  
1102009-HCBS (Home and Community-Based Services)

**Investigator(s):**

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Licensing Division  
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**Suspected Maltreatment Reported:**

It was reported that a vulnerable adult (VA) pulled off his/her toenail with pliers while not supervised by two staff persons (SP1 and SP2).

**Date of Incident(s):** June 14, 2025

**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 July 9, 2025; from documentation at the facility and medical records; and through five interviews conducted with two of the VA's case managers (CM1 and CM2), two staff persons (SP1 and SP2), and the VA. The VA was not subject to guardianship and was the only client at the facility.

The VA's plans stated that the VA was diagnosed with schizoaffective disorder (bipolar type), chronic pain, osteoarthritis, and morbid obesity. The VA had a "significant history of delusional thoughts, paranoia, suspiciousness, aggression, irritability, and medical noncompliance." The VA often called law enforcement "as a result of [his/her] paranoia" and law enforcement typically contacted SP1 prior to responding to determine if there was an "actual emergency response needed."

The VA's plans stated that the VA required the "presence" of staff persons while services were being provided. This included one to one staffing at all times, with two to one staffing for two hours daily for personal cares. The facility also provided six hours of awake overnight staffing. The VA's plans did not say that the VA had to be in eyesight of staff persons at all times.

Staff persons assisted the VA with transportation, cares, help with household tasks, meals, and taking medications. The VA used knives for preparing food and the plan stated that staff persons would reassess if safety issues arose. The VA enjoyed talking on the phone, watching sports, had a "great memory" for numbers, and preferred to be on his/her own rather than in group settings.

SP1 provided the following information:

- During a hospital visit a month prior to the incident (May 2025), the VA was seen for an unrelated medical issue. During the visit, the VA asked the doctor to remove his/her toenail. The doctor refused to remove the toenail, stating that the VA was not there that day to have his/her toenail examined. When the doctor left, the VA told SP1, "Fuck it," and that s/he would remove the toenail him/herself. There was "no issue" or "injury" with the VA's toenail, but the VA believed that it contributed to the VA's mobility issues. SP1 reminded the VA that removing his/her toenail would be "dangerous" and offered to schedule a pedicure appointment. The VA declined and talked off topic, was "paranoid," and the conversation ended. SP1 was "concerned," but the topic did not come up again.
- On June 14, 2025, between 9:40 p.m. and 10:00 p.m., SP1 and the VA were outside while the VA smoked and talked on the phone. SP1 was sitting beside the VA and when the VA finished his/her cigarette, the VA went into his/her bedroom. The VA put on music and was playing it "loud." SP1 grabbed clean laundry, placing the VA's laundry in the living room, then putting SP1's laundry away in his/her own bedroom, located directly across the hall from the VA's bedroom. Approximately five minutes passed from the time they came inside to the time SP1 was in his/her room with the laundry.
- SP2 picked up the VA's laundry to bring to the VA's bedroom. When SP2 opened the door, s/he saw the VA bleeding from the foot and saw a pair of pliers. SP2 did not say anything and turned around to knock on SP1's bedroom door, indicating something was going on with the VA. SP1 saw that the VA was

bleeding and asked the VA what s/he did. The VA replied, "I took off my nail." SP1 asked the VA why, and the VA replied, "Because the doctor did not take it off the month prior." SP1 told the VA that s/he "can't do that" and that that was why SP1 scheduled an appointment to have it checked.

- Immediately after, SP1 and SP2 got the VA into a seated position and worked on cleaning the toe and applied a bandage. The VA's nail was "completely" removed. SP1 asked the VA if they could go to the hospital and the VA told them to get out of his/her bedroom. The VA "yelled" that s/he did not want to go to the hospital. The VA allowed SP1 and SP2 to continue to "apply first aid" and treat the area. The VA continued to refuse to go to the hospital up until the following morning. Every time the VA went to the hospital, s/he thought that the hospital would try to "commit" him/her again.
- The VA would not allow SP1 to see his/her toe, did not shower at first after the incident, would sleep in shoes, or put them on first thing after waking. SP1 could not touch the VA's foot without first asking the VA. Two days prior to this interview, SP1 saw the VA's toe and it was "healing."
- SP1 was unsure where or when the VA got pliers and had not seen them before. When the VA moved in, s/he arrived with a duffel bag and did not let any staff persons touch the bag. The pliers were "very rusty" like s/he had them a long time and did not belong to SP1. SP1 did not, and was not supposed to "inventory" the VA's belongings when s/he moved in.

The VA provided the following information:

- The VA pulled off his/her own toenail because the toe was "swelling up" and the VA's toe and legs "did not look great" with the color, and the VA's toenail regularly would "catch" on the VA's socks or the floor when s/he went barefoot. The VA "figured" removing the toenail "would take care of it" and "get the infection out." It was not on the "part" of the facility or their staff persons that the VA removed his/her toenail.
- The VA had removed his/her toenails two or three times before and asked a "guy" (presumed to be the VA's doctor) to look at the toenails for removal. S/he "just clipped them" and "wouldn't listen" to the VA. The VA was offered medications, but the toenails "always grew in dead."

Facility documentation, documented by SP1 showed:

- An email dated June 15, 2025, and sent by SP1 at 1:33 p.m. to CM1 and CM2, stated that on the previous evening, June 14, 2025, at approximately 10 p.m., the VA used a pair of pliers to pull off one of the VA's toenails. The email stated, "Despite lots of convincing from the staff [persons], letting [the VA] know how dangerous that could be," that the VA went to his/her room and still pulled out the nail. The email went on to state that the VA believed that the nail was part of the VA's "mobility problem" and since the doctor would not help the VA, the VA could "just do it" him/herself. SP1 and SP2 assisted the VA into a sitting position and applied "first aid." The VA "refused" to go to the hospital and said that s/he was "fine." The pliers were the VA's personal belongings that were kept in the VA's bedroom. Staff persons were unaware that the VA had pliers until after the VA removed his/her toenail. Photos of the VA's foot and pliers accompanied the email to CM1 and CM2. (Investigator's note: the photos were taken by SP1 on June 14, 2025, at about 10:25 p.m.)
- An email dated June 16, 2025, from CM1 to SP1/the facility, sent at 12:43 p.m. asked for clarification on how "an individual who requires both 1:1 and 2:1 supervision, was allowed to be alone after [s/he] mentioned [his/her] intention to carry out this action?"

- In an email response from SP1 to CM1 and CM2 sent on June 16, 2025, SP1 further explained that the VA had discussed having the nail removed weeks earlier when they were at the hospital for an unrelated injury. The VA asked the doctor to remove the nail and the doctor “refused.” The VA said that s/he would “do it” him/herself. SP1 told the VA how “dangerous” it could be to do that. SP1 said that s/he offered to schedule a doctor’s appointment for the VA’s nail and that the VA declined, stating s/he would wait for a future appointment. Since the VA was recently “off commitment [orders],” the VA would regularly remind staff persons and others that the VA could “do as [s/he] so please[d].” SP1 explained in the email that staff persons did their best to “persuade” him/her to see doctors. They also explained that the VA did not want staff persons “invading” his/her privacy when alone in his/her bedroom. The VA had been in the living room and went into his/her bedroom and removed the nail. Staff persons checked on the VA from “time to time” when s/he was alone in his/her bedroom, which was how this incident was discovered and first aid was applied. The VA did not like being checked on by staff persons.

SP2 provided the following information:

- SP2 provided help when needed at the facility and was helping fill in for another staff person who was on an extended time away from the facility. On the night of the incident, SP2 arrived at about 10 p.m. and the VA was in his/her bedroom. SP1 and SP2 were working on laundry and SP2 went into the VA’s bedroom to deliver laundry. SP2 saw blood on the VA’s legs and toenails and there was a pair of pliers nearby. SP2 saw an area that was bleeding from a “little cut,” and it did not look like the VA tore off his/her entire nail.
- SP2 told SP1 to come assist and they provided first aid to the VA by cleaning the area, applying a bandage, and attempting to get the VA to go to the hospital. The VA declined. The VA did not say anything further about it and did not talk much to SP2 because the VA preferred SP1. SP2 was not aware of the VA giving any warning that s/he was going to do this.
- Staff persons were not concerned about the VA “hurting” him/herself in general.
- SP2 looked at the VA’s toe on July 16, 2025, and it looked as though it had “completely healed.”

CM1 provided the following information:

- On June 14, 2025, the VA “ripped off” one of the toenails from one of the VA’s “large toe,” and the facility was not aware that the VA had pliers. The VA refused medical care.
- When SP1 told CM1 that the VA had previously discussed his/her “intent” to take off the toenail, CM1 asked SP1 why they then left the VA “alone.” SP1 said that it was not recent that the VA discussed taking off his/her toenail, but that it was “some days” earlier and at that time, staff persons attempted to convince the VA that it would be “dangerous” to do that. Staff persons thought that the VA thought the toenail was contributing to his/her “mobility issues” and that the doctor would not help with removal. Staff persons told the VA that there was an appointment scheduled for his/her toenails, but the VA did not want to wait and did not go to the appointment.
- CM1 was unaware of there being anything “going on” with the VA’s toenail other than maybe “discomfort” for the VA, and the VA did not have a history of self-harm.
- CM1 provided photos taken by SP1 of the VA’s bandaged big toe (left foot), and a pair of pliers next to apparent bloody medical cloth which were taken after the toenail removal. These pictures were said to be taken on the night of the incident, June 14, 2025. The facility sent an email over the weekend and CM1 received that email the following Monday, June 16, 2025.

- Typically, if the VA “refused” to do something that was in his/her plan, the facility would reach out to CM1 and CM2 and communicate that they attempted to work with the VA on it. CM1 would often attempt to redirect the VA, but the VA would often refuse.
- The VA had “issues” with mobility and “delusions” about people, places, and events that had happened and was “not always an accurate witness.”
- CM1 was concerned that the VA was doing things at the facility “without needing support” from staff persons and if staff persons were providing the required supervision.

CM2 provided the following information:

- The VA recently “ripped off” one of his/her toenails with a pair of pliers and was a “high risk individual” with a “wide range of different paranoid delusions.” The VA’s baseline showed a “high level of paranoia.” The VA was “less hostile and angry” when on a “decent level” of medications.
- CM1 gave the facility “some pushback” when CM1 asked, “How could this possibly happen if they’re being paid a high rate to monitor [the VA]?” CM2 explained that staff persons were not required to “monitor” the VA 24/7. CM1 went on to explain that on the night of the incident, staff persons did “safety checks” and saw the VA on the bed with a bloody rag. Staff persons “responded” to the incident as soon as they saw it.
- CM1 was “concerned” because in the email sent by the facility (SP1), it sounded as if the VA “threatened” to remove his/her toenail, and then “immediately” did so. SP1 clarified to CM1 and CM2 that the VA did not “threaten” to remove the toenail before s/he did it, rather, it was “days earlier” at a medical appointment. CM2 added that it was not as if the VA “threatened” right before and staff persons “let” the VA do it.
- SP1 had been “good to work with,” and the VA had done well while living at the facility with the care provided. SP1 informed CM1 and CM2 when things happened, and the VA had no previous history of “self-harming behaviors.” CM1 thought that it was “not reasonable” for the VA’s team to have “presumed [the VA] would be capable” of removing his/her toenail.
- The VA had a little bit of “narcissism” and felt like s/he “knew more than” everyone else, including social workers and doctors. CM2 and the VA’s original primary doctor agreed that the VA could fall or succumb to other “health risks” that could be “lethal” to the VA if the VA was off “commitment.” The VA had the right to decline medical care for him/herself and in the past, when an ambulance was called, the VA refused help from Emergency Medical Services.
- The VA had “rights to privacy” and staff persons could not search the VA’s “stuff” all the time. If staff persons had a reason to believe that the VA had a “substance” they could be “justified” to search the VA’s belongings, but not “randomly” just to see if the VA had “anything dangerous.”
- CM2 thought that CM1 seemed to be “unclear” as to what the facility’s responsibilities were regarding supervising the VA. The VA was likely supervised “every minute” when s/he was not in his/her own

bedroom or outside smoking. Staff persons were allowed to stay inside when the VA smoked. Staff persons were aware of where the VA was and keeping a “relatively close watch.” Having a staff person

“glued to [the VA’s] hip” would be “intrusive” and “beyond what most reasonable caretakers could take.” Even in a “nursing facility,” the VA would not have had that level of supervision.

- The VA was legally free to leave the facility now that s/he was off commitment and this could result in the VA ending up “homeless,” which had happened in the past. The VA called law enforcement “so frequently” on staff persons that law enforcement always called SP1 prior to responding in person, any time there was a call by the VA to see if there was a need for law enforcement’s response.
- The VA had an issue with “judgement” and was not an “accurate historian,” however could recite memorized numbers from years earlier. The VA seemed to have a difficulty remembering short term events, but did better with long-term memory.
- The things that the VA needed more than one staff person to assist with were “not scripted” or scheduled. SP1 lived at the facility 24/7 but could not estimate when the VA might need a second staff person for help. It was “based on need” and the VA’s two to one staffing hours had recently been cut down.

SP1 provided the following additional information:

- Another staff person lived at and worked for the facility along with SP1 to provide care for the VA, but that staff person was on an extended time away prior to the incident, so SP1 brought in SP2 for help with staffing ratios while the other staff person was unavailable. SP1 called SP2 when the VA needed help with cares and to assist with the awake overnight schedule. SP2 stayed for more than the two hours covered by the two to one staffing when SP1 needed extra help. Caring for the VA was SP1’s full time job.
- Until recently, the VA had been on civil commitment and typically “complied” with things out of fear of SP1 “reporting” things the VA did or did not do. Once off commitment, the VA would stop talking to SP1, stating that s/he was “off commitment” and that staff persons could not tell the VA what to do and regularly stated that staff persons were “invading [the VA’s] privacy.” The VA also repeatedly stated that s/he could leave the facility. SP1 typically left the VA’s bedroom door partially open and would knock on the door to check on the VA from time to time.
- SP1 tried to keep “eyes on” the VA, but when the VA wanted “privacy,” SP1 and other staff persons let the VA be in his/her room alone or would stay inside if the VA wanted to smoke outside of the front door of the facility alone. The VA’s sleeping schedule varied, and s/he could be up anywhere from three to nine times to smoke during the night.
- Prior to being off commitment, the VA’s routine was “stable,” and s/he preferred solitude over social activities.
- The VA was “very” verbal, but “paranoid” and would call law enforcement or the “FBI” to report various things, such as the VA’s “stolen identity.”

Medical records did not address any issues related to the VA’s toe, but the physician’s discharge note stated, “Remember, your care today was on an emergency basis and treatment was not intended to be a substitute for ongoing medical care from your primary care physician.”

All staff persons interviewed were trained on the Reporting of the Maltreatment of Vulnerable Adults Act and the VA’s plans.

**Conclusion:**

Information from SP1, CM1, and CM2 showed that on June 14, 2025, at about 10 p.m., the VA was in his/her bedroom and removed his/her toenail with a pair of pliers belonging to the VA and that there was blood. SP2 stated that the VA did not remove the toenail, but made a "small cut" on his/her toe. Aside from that detail, SP2's information aligned with information provided by SP1. The VA stated that his/her toenail was catching on his/her socks and that his/her leg and toe looked "swollen" and the "color" did not look great. The VA said that s/he removed his/her toenail to "take care of" the issues and "get the infection out" of the toenail. The VA also stated that the facility was not responsible.

CM1 stated that SP1 sent an email to CM1 and CM2 stating that the VA talked about pulling off his/her toenails and then did so without intervention from staff persons. However, SP1 and CM2 stated that the VA talked about pulling off his/her toenails on a prior date, with CM2 stating it was "days" earlier and SP1 stating that it was a month earlier at a doctor's appointment. SP2 was not aware of the VA giving any warnings about doing this.

CM1, CM2, SP1 and SP2 stated that the VA declined a trip to the hospital or medical assistance other than to allow SP1 and SP2 provide "first aid," which involved cleaning and bandaging the injured area.

The VA's plans did not say that staff persons had to have eyes on the VA at all times, as the VA was his/her own guardian. CM2 and SP1 stated that the VA did not like his/her "privacy invaded," and CM2 added that staff persons were not required to "monitor" the VA "24/7." CM2, SP2, and SP1 stated that the VA did not have a history of self-harming, and CM2, CM1, and SP1 stated that the VA might have thought that pulling off the VA's toenail would improve his/her mobility.

Given that the VA was allowed to be in his/her bedroom without supervision, that the VA did not have a history of self-harm, that the VA had not expressed recent intent to remove his/her toenail, and that upon observing the VA's injury, SP1 and SP2 offered medical care that the VA refused, and cleaned and bandaged the area, there was not a preponderance of the evidence whether SP1 or SP2 failed to supply the VA with care or services, including supervision.

*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's *Internal Review* stated that policies and procedures were adequate and followed. There was not a need for corrective action or additional staff person training.

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

No further action taken.