

**SDM[®] APS
SAFETY
ASSESSMENT
INTER-RATER
RELIABILITY
FINDINGS**

MINNESOTA DEPARTMENT OF HUMAN SERVICES

February 2026

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ABOUT EVIDENT CHANGE

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INTRODUCTION

The Minnesota Department of Human Services Adult Protective Services (APS) is partnering with Evident Change to develop a Structured Decision Making® (SDM) safety assessment for APS.

The purpose of inter-rater reliability (IRR) testing is to assess whether the safety assessment supports workers in consistently determining if an adult may be at risk of imminent harm. IRR testing also highlights areas of the tool that may require revised definitions for clarity or additional training prior to implementation.

IRR testing occurred September 3–19, 2025. This report summarizes the results and guides APS in supporting successful implementation of the safety assessment.

WHAT IS INTER-RATER RELIABILITY?

IRR measures consistency. It reflects the degree to which different raters reach the same conclusion about a scenario when reviewing the same information. IRR is essential because, without it, service recommendations for vulnerable adults could vary depending on which caseworker completes the assessment.

Evident Change evaluates IRR using percent agreement, a straightforward measure that shows how often workers make the same decision. Percent agreement is calculated by dividing the number of times raters agreed on a response for an item by the total number of responses for that item.

Specifically, Evident Change reviews the following three indicators.

- **Overall percent agreement:** The total number of agreements across all vignettes for an item, divided by the total number of responses.
- **Minimum percent agreement:** The lowest percent agreement observed for an item across vignettes.
- **Maximum percent agreement:** The highest percent agreement observed for an item across vignettes.

When percent agreement is below 75%, Evident Change recommends addressing inconsistencies by revising item definitions or providing targeted training. In the tables that follow, shaded cells indicate agreement levels below this 75% threshold.

METHODS

For the IRR test, 42 workers, supervisors, and Department of Human Services (DHS) project staff across Minnesota volunteered to participate in testing. During the two-week testing period, 36 participants (excluding DHS project staff) completed 278 unique tests, and DHS project staff completed 47 unique tests, of the safety item definitions. Because the DHS project staff had prior exposure to the assessment, they were excluded from the primary data analysis. Results from DHS project staff tests were used as context for Evident Change's review of the IRR results and are not described in this report.

The SDM[®] safety assessment consists of three sections: imminent danger factors, recommended immediate safety interventions, and safety decision. IRR testing involved just the imminent danger factors section and did not cover the recommended immediate safety intervention section. This is because outcomes from that section (whether an adult was offered an intervention, what type of intervention, and if the intervention was implemented) relate more to the specific danger identified and to availability of interventions than to definitional thresholds.

Because identifying safety interventions when imminent danger factors are present is critical to determining the safety decision, participant agreement on the safety decision could not be tested. However, Evident Change was able to examine how often participants agreed on the presence of any imminent danger factor versus none.

Three participants completed at least one vignette more than once; in those cases, only the most recent vignette was kept in the dataset.

RESULTS

The sections tested showed strong overall percent agreement. A total of 33 participants completed all eight vignettes, and the overall average number of vignettes completed was also eight. Each vignette received between 38 and 42 responses, with a total of 278 responses.

The average overall percent agreement for the nine imminent danger factors was 90%. The following eight had overall percent agreement of 84% or more.

- An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted (96%).
- The adult is likely to or will continue to be physically abused (90%).

- The adult has an illness or condition AND no way to obtain necessary medical care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician (93%).
- The adult has no food or water AND no way to obtain food or water which will likely result in serious injury, harm, or loss of health requiring medical care by a physician (92%).
- The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician (84%).
- The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician (89%).
- The adult's resources are being mismanaged or misappropriated AND there is an immediate concern for preserving assets from fraud or theft (99%).
- Other imminent danger factor (95%).

One item had overall agreement of 75%: The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.

The following six imminent danger factors had minimum agreement below 75%, meaning that for each of those imminent danger factors, at least one vignette had agreement below 75%.

- An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted (71%).
- The adult is likely to or will continue to be physically abused (66%).
- The adult has no food or water AND no way to obtain food or water which will likely result in serious injury, harm, or loss of health requiring medical care by a physician (66%).
- The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician (55%).
- The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician (51%).
- The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician (51%).

Maximum agreement was 100% for the following seven of the nine factors.

- An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted.

- The adult is likely to or will continue to be physically abused.
- The adult has an illness or condition AND no way to obtain necessary medical care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.
- The adult has no food or water AND no way to obtain food or water which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.
- The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician.
- The adult’s resources are being mismanaged or misappropriated AND there is an immediate concern for preserving assets from fraud or theft.
- Other imminent danger factor.

The following remaining two factors had maximum agreement of 97% each (Table 1).

- The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.
- The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.

This means that for the majority of factors, at least one vignette had 100% agreement.

Table 1: Safety Assessment Results Section 1. Imminent Danger Factors (N = 278)

ITEM	% AGREEMENT OVERALL	% AGREEMENT MINIMUM	% AGREEMENT MAXIMUM
An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted.	96%	71%	100%
The adult is likely to or will continue to be physically abused.	90%	66%	100%
The adult has an illness or condition AND no way to obtain necessary medical care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	93%	82%	100%
The adult has no food or water AND no way to obtain food or water which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	92%	66%	100%

ITEM	% AGREEMENT OVERALL	% AGREEMENT MINIMUM	% AGREEMENT MAXIMUM
The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	84%	55%	97%
The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	75%	51%	97%
The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	89%	51%	100%
The adult's resources are being mismanaged or misappropriated AND there is an immediate concern for preserving assets from fraud or theft.	99%	94%	100%
Other imminent danger factor.	95%	83%	100%

Note: Shaded cells indicate percent agreement below 75%.

For the eight vignettes tested, agreement regarding the presence of an imminent danger factor was good, with only vignette 8 (73%) having agreement below 75% (Table 2). For vignette 8, nine raters identified no imminent danger factor, while 24 raters identified at least one (not shown). For the other seven vignettes, agreement on the presence or absence of any imminent danger factor ranged from 100% for vignettes 1, 2, and 5 to 85% for vignette 6.

Table 2: Imminent Danger Factor Identification

VIGNETTE	NUMBER OF RESPONSES	PERCENT AGREEMENT	IMMINENT DANGER FACTOR IDENTIFIED: NO	IMMINENT DANGER FACTOR IDENTIFIED: YES
1	36	100%	0	36
2	36	100%	0	36
3	35	91%	3	32
4	35	97%	1	34
5	35	100%	0	35
6	34	85%	5	29
7	34	91%	31	3

VIGNETTE	NUMBER OF RESPONSES	PERCENT AGREEMENT	IMMINENT DANGER FACTOR IDENTIFIED: NO	IMMINENT DANGER FACTOR IDENTIFIED: YES
8	33	73%	9	24

Note: Shaded cells indicate percent agreement below 75%.

RECOMMENDATIONS

The safety assessment had high overall agreement. Regarding the imminent danger factors, Evident Change recommended making minor language changes to certain items with minimum agreement below 75%.

Evident Change recommended the following changes.

- Consider an item stem change for imminent danger factor 1 (harassment and exploitation), as this imminent danger factor only mentioned sexual assault and could potentially be limiting as it does not consider sexual harassment or exploitation.
- Potential definition changes for imminent danger factors 5 and 6 (care and supervision) to expand on what care and supervision look like in the definitions rather than just having these as examples in the definition. Evident Change also suggested adding practice guidance to the safety assessment policy and procedures (P&P) manual about how to best make the distinction between an adult not meeting their own needs and a support person not meeting the adult’s needs.
- For imminent danger factor 7, Evident Change recommended removing “extreme heat or cold” from the item stem and including this as an example in the definition instead.

These changes intend to clarify areas that may have resulted in lower consistency during testing and have already been incorporated either into an updated version of the P&P manual or into the training plan for the safety assessment.

Evident Change also recommends that future training sessions and webinars focus on imminent danger factors that had lower minimum agreement to support workers and supervisors in their understanding, use, and review of the safety assessment.

In several vignettes (Appendix A), participants selected an imminent danger factor due to a mention of circumstances without enough information to indicate the adult was in imminent danger. For example, in vignette 4, imminent danger factor 4 (“The adult has no food or water and no way to obtain food or water”) had low agreement, but there was no indication that this was true or presenting an imminent danger for the adult. Similarly, in vignette 5, there was low agreement about imminent danger factor 7 (“The adult is exposed to extreme heat, cold, or environmental hazards”). Though this vignette was designed for testing this

imminent danger factor, the intended selection was “no.” Although the home was 84 degrees during the face-to-face visit, there was no indication of any imminent danger or impact. Evident Change recommends that training include an increased focus on the idea of imminent danger versus needs to support staff in solidifying their understanding of the difference between imminent danger factors and needs.

APPENDIX A: IRR RESULTS BY VIGNETTE

Table A shows the percent agreement for each imminent danger factor across the eight vignettes. For instance, among the 36 participants who completed Vignette 1, 100% selected the same response to the item “An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted.” Shaded cells highlight the following vignettes and items with agreement below 75%.

- Vignette 1; Item: The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 67% agreement (N = 36).
- Vignette 2; Item: The adult is likely to or will continue to be physically abused; 67% percent agreement (N = 36).
- Vignette 3
 - » Item: The adult is likely to or will continue to be physically abused; 66% agreement (N = 35).
 - » Item: The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 51% agreement (N = 35).
- Vignette 4
 - » Item: The adult has no food or water AND no way to obtain food or water which will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 66% agreement (N = 35)
 - » Item: The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 51% agreement (N = 35)
- Vignette 5; Item: The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 74% agreement (N = 35).
- Vignette 6
 - » Item: An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted; 71 % agreement (N = 34).
 - » Item: The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 68% agreement (N = 34).
- Vignette 8
 - » Item: The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 55% agreement (N = 33).

- » Item: The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician; 52% agreement (N = 33).

Table A: IRR Results by Vignette Imminent Danger Factors

ITEM	1	2	3	4	5	6	7	8
An incident of sexual assault is alleged and the adult has not received a sexual assault examination OR the adult is likely to be sexually assaulted.	N = 36 100%	N = 36 100%	N = 35 100%	N = 35 100%	N = 35 100%	N = 34 71%	N = 34 100%	N = 33 100%
The adult is likely to or will continue to be physically abused.	N = 36 97%	N = 36 67%	N = 35 66%	N = 35 100%	N = 35 100%	N = 34 94%	N = 34 94%	N = 33 100%
The adult has an illness or condition AND no way to obtain necessary medical care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	N = 36 83%	N = 36 97%	N = 35 97%	N = 35 89%	N = 35 97%	N = 34 100%	N = 34 97%	N = 33 82%
The adult has no food or water AND no way to obtain food or water which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	N = 36 86%	N = 36 100%	N = 35 89%	N = 35 66%	N = 35 100%	N = 34 100%	N = 34 97%	N = 33 100%
The adult does not meet their own needs for necessary care and supervision AND they are unable or unwilling to obtain necessary care which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	N = 36 67%	N = 36 89%	N = 35 89%	N = 35 89%	N = 35 97%	N = 34 94%	N = 34 94%	N = 33 55%
The adult is dependent on a service or support that does not meet their needs for necessary care or supervision which will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	N = 36 89%	N = 36 75%	N = 35 51%	N = 35 91%	N = 35 77%	N = 34 68%	N = 34 97%	N = 33 52%

ITEM	1	2	3	4	5	6	7	8
The adult is in extreme heat, cold, or other environmental hazards that will likely result in serious injury, harm, or loss of health requiring medical care by a physician.	N = 36 97%	N = 36 100%	N = 35 94%	N = 35 51%	N = 35 74%	N = 34 100%	N = 34 100%	N = 33 97%
The adult's resources are being mismanaged or misappropriated AND there is an immediate concern for preserving assets from fraud or theft.	N = 36 100%	N = 36 100%	N = 35 97%	N = 35 100%	N = 35 100%	N = 34 100%	N = 34 100%	N = 33 94%
Other imminent danger factor.	N = 36 100%	N = 36 97%	N = 35 91%	N = 35 97%	N = 35 83%	N = 34 91%	N = 34 100%	N = 33 100%

APPENDIX B: IRR TESTING VIGNETTES

INTER-RATER RELIABILITY TESTING INSTRUCTIONS: SDM[®] SAFETY ASSESSMENT

WHAT IS INTER-RATER RELIABILITY TESTING?

Inter-rater reliability testing measures the extent to which different workers will make the same decision when given the same information. It is used to test the reliability of Structured Decision Making[®] (SDM) assessments. Reliability is important because if assessment items and definitions are not reliable, adults in similar situations may receive different recommendations for adult protective services (APS).

HOW WILL EVIDENT CHANGE TEST THE RELIABILITY OF THE SDM SAFETY ASSESSMENT?

We will ask participants to read a series of vignettes describing situations that require a safety assessment. Participants will complete an SDM[®] safety assessment for each vignette. Responses will be collected in a web survey, which will allow Evident Change to analyze data to calculate a measure called percent agreement for each item on the assessment tool. This determines the percentage of participants who agreed on the rating for each item or on the decision.

WHAT WILL BE DONE WITH THE RESULTS?

Evident Change will produce a summary of the findings. The findings will result in recommendations, which may include refining items and/or definitions to strengthen assessment reliability prior to implementation.

HOW DOES THIS WORK?

Please read each vignette in this packet, then complete the survey for that vignette. Use only the information available in the vignettes to complete the safety assessment. Vignettes describe all information known at the time of screening. Additional information is unknown. Complete the assessment independently. Please do not consult with others during the test.

VIGNETTES

VIGNETTE 1

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable

- Name: Frances Clooney
- Age: 90
- Race: Caucasian
- Gender: Female
- Physical Location: 1222 Mayo Ave, Rochester, MN 55432, Olmsted Co.
- Other Address: Assisted Living Center, 54343 Capital Ave, St. Paul, MN 55122, Ramsey Co.

Person Alleged Responsible

- Name: John Clooney
- Age: 65
- Race: Caucasian
- Gender: Male
- Physical Location: 1222 Mayo Ave., Rochester, MN 55432, Olmsted Co.

Reporter

- Name: Linda Johnson
- Address: 1234 Spice Street, St. Paul, MN 55122
- ljohnson@home.com 555-666-333

ADULT MALTREATMENT TAB

- **Source:** Family
- **Reporter:** Johnson, Linda

Incident:

- Estimated date/time: 07/20/2023 04:00PM
- Location of incident: 1222 Mayo Ave., Rochester, MN 55432 Olmsted Co.
- County of incident: Olmsted
- Reporter Requests Initial Disposition: Yes

VICTIM INFORMATION TAB**Alleged Victim:** Clooney, Frances**Facility/Provider Information:** Resident of facility**VA Provider Name:** Assisted Living Center**VA Deceased:** No**VA Is Deceased as a Result of Suspected Maltreatment:** No**VA Has Experienced Serious Injury as a Result of Maltreatment:** No**Disabilities:** Frailty of aging, Impaired memory**Needs Assistance:** Clothing, financial management, food, health care, hygiene, safety, shelter, supervision, toileting, unable to protect self from abuse/neglect/financial exploitation**Receives Services:** Assisted living**Diagnosis if Known:** Dementia**DESCRIPTION OF INCIDENT TAB**

Reporter called to report that AP took VA from the assisted living center in Saint Paul where VA was living and moved VA to AP's home in Rochester. The memory care assisted living center called Reporter after VA did not return from two-night visit with AP. When the assisted living center called AP, AP said VA will not return and that AP is taking care of VA now. Reporter stated that AP cannot take care of VA's high needs. VA has severe dementia and needs assistance with most activities of daily living. However, AP does not believe VA should be in assisted living even though years ago, VA, VA's husband (now deceased), and the rest of the family made that decision before the dementia diagnosis.

VA has called Reporter every day crying because VA wants to come back home. AP told VA that AP would take care of VA now, and AP persuaded VA to give AP VA's bank account information. Reporter helps with VA's finances and has already seen large withdrawals within the past week. This bank account includes all the money VA has: inheritance, Social Security, and savings. Reporter is afraid that AP will not take care of VA, and fears if they cannot get VA back, AP will take all the money. Reporter feels helpless because Reporter does not have the resources to get VA back, and is afraid of AP.

ALLEGATIONS TAB

Alleged perpetrator name: Clooney, John

Nature of Allegation

- Emotional or mental abuse—Forced separation of the VA from another person against the wishes of the VA, or legal representative’s wishes
- Financial exploitation not fiduciary relationship—Acquired possession/ownership/control of VA’s money/possessions using undue influence/harassment/duress/fraud

IMPACT/EFFECT ON VA TAB

Worsening physical or mental health: VA is crying every day

Theft, loss, transfer, unauthorized expenditures, fraud, or the withholding of money or property:

- Dollar amount: \$10,000
- Type of asset: Cash

ROLES TAB

- Clooney, John: Alleged perpetrator
- Clooney, John: Son
- Johnson, Linda: Reporter
- Johnson, Linda: Daughter
- Clooney, Frances: Alleged victim

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: None

Notification Made by Reporter: None

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

Upon arriving at the home in Rochester for the initial face-to-face visit, the APS worker was greeted at the door by AP, who allowed the APS worker entry to the home. The VA was seated in a recliner in the small living room, dressed in a stained nightgown and cardigan. Her hair was unkempt and matted, and she smelled of urine. She appeared thin but not malnourished, and somewhat disoriented, but she brightened when the worker introduced herself. She quickly became tearful and repeatedly stated, “I just want to go back home,” and “I don’t know why I’m here.”

The home itself was moderately cluttered with stacks of papers and clothing on furniture. There was a strong smell of stale food, and dirty dishes were piled in the sink. When asked about meals, the AP vaguely stated that the VA doesn't have much interest in eating when he offers her meals.

The VA demonstrated significant cognitive impairment during the visit, often losing track of the conversation and asking the worker the same question several times. She became visibly anxious whenever AP answered questions for her. The AP acknowledged having access to VA's bank account, stating he was "just trying to protect her money from the place in Saint Paul." When the worker asked about the recent withdrawals noted by the reporter, AP responded tersely that it was "none of their business" and would not provide details.

VA did not appear able to independently manage her own finances, medications, or personal care at this time and was dependent on AP for all these needs. AP, however, showed little understanding of VA's high level of care needs and dismissed suggestions to bring in additional help or return her to a facility. The VA requires a walker to get around, and the worker did not see one in the home. The AP stated that the VA does not need to get around, and she enjoys sitting in the recliner.

Upon leaving the home, the worker made a call to the reporter to inquire further about the VA's finances. The reporter told the worker that the AP has withdrawn \$10,000 from the VA's account in the past week. The reporter is worried that if this keeps up, the VA will no longer have enough funds to support their stay in the assisted living center.

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 2

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Linda Reed

- Age: 80
- Race: Caucasian
- Gender: Female
- Physical location: 914 Irvine Ave. NW, Bemidji, MN 56601, Beltrami Co.

Person Alleged Responsible: Jack Reed

- Age: 82
- Race: Caucasian
- Gender: Male
- Physical location: 914 Irvine Ave. NW, Bemidji, MN 56601, Beltrami Co.

Reporter: Jill Wagner, nurse practitioner

- Address: 1300 Anne St. NW, Bemidji, MN 56601, Beltrami Co.

ADULT MALTREATMENT TAB

Source: Medical provider

Reporter: Wagner, Jill

Incident:

- Estimated date/time: 7/20/2023, 11:45 a.m.
- Location of incident: 914 Irvine Ave. NW, Bemidji, MN 56601 (VA's home)
- County of incident: Beltrami

Reporter Requests Initial Disposition: No

VICTIM INFORMATION TAB

Alleged Victim: Reed, Linda

Facility/Provider Information: N/A

VA Provider Name: N/A

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: Yes

Disabilities: Impaired memory, mental

Needs Assistance: Safety, supervision, unable to protect self from abuse/neglect/financial exploitation

Receives Services: Unknown

Diagnosis if Known: N/A

DESCRIPTION OF INCIDENT TAB

The VA was taken to the doctor by the VA's caregiver, who noticed blood in the VA's urine and became concerned about the possibility of a urinary tract infection.

Upon examining the VA, the reporter discovered bruising and abrasions on the VA's labia consistent with ongoing forced penetration. There was a mixture of older and newer bruises and abrasions. The VA reported that the AP has been forcing themselves on the VA despite attempts to push the AP off. The VA reported that the last time this occurred was three weeks ago, but the reporter said the VA has "memory issues," so the VA's description is not always clear about when things happened chronologically.

The reporter noted that the injuries were more recent than three weeks. The VA's son told the reporter that this has happened before, and when he is around, he tries to make sure the AP is not alone with the VA, but he cannot be around all the time. He says it is a difficult issue to talk about and deal with for him. The son said he has not called law enforcement about this because he is worried about how the VA and AP would react, and he would like to keep his involvement minimal.

The VA pleaded with the reporter not to send the VA back home, saying the AP is "waiting for me at home right now."

ALLEGATIONS TAB

Alleged Perpetrator Name: Reed, Jack

Alleged Perpetrator Description: N/A

Nature of Allegation:

- Sexual abuse—criminal sexual conduct 1st–5th degree
- Physical abuse—use of manual or physical restraint

IMPACT/EFFECT ON VA TAB

Hospitalization or medical treatment required

- Diagnosis or symptoms: blood in urine, various bruising and abrasions to VA's labia
- Treatment date: 7/20/23
- Name of Hospital or Provider: Sanford Bemidji Medical Center
- Effect on VA: concern for safety, emotional harm, physical harm

Physical, emotional, mental, or sexual injury

- Identify and describe the injury: blood in urine, various bruising and abrasions to VA's labia
- Treatment received: yes
- Name of Medical provider: Sanford Bemidji Medical Center

ROLES TAB

- Reed, Jack: Alleged perpetrator
- Reed, Jack: Spouse
- Reed, Linda: Alleged victim
- Reed, Sean: Caregiver
- Reed, Sean: Son
- Wagner, Jill: Reporter
- Wagner, Jill: Nurse practitioner

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: other, VA lives with abusive spouse

Notification Made by Reporter: N/A

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

The APS worker met the VA at the medical center to begin the investigation. The VA appeared frail and somewhat disoriented but was alert to person and place. She was dressed in loose slacks and a sweater, both clean but wrinkled, and her hair was pulled back loosely.

The APS worker spoke with the VA privately in a quiet consultation room, away from the physician and the son. The VA became visibly agitated when discussing the allegations, wringing her hands, speaking softly, and glancing toward the door as though afraid of being overheard. She confided that she dreads being alone in the house with AP. She stated, "He waits until no one is around," and described how she tries to physically push AP away when he "climbs on me," but that he overpowers her. The VA began to cry as she said she feels trapped and helpless, adding, "I don't know what to do anymore. No one listens." When asked what she feared would happen if she returned home, VA became visibly shaken and whispered, "He's waiting for me there right now . . . it'll just keep happening. I can't stop him." VA's affect was fearful, her voice low, and her body language tense throughout the conversation. She repeatedly expressed a desire not to go back to the home and pleaded for someone to help her. Her speech became disorganized when asked for specific dates the assaults occurred, but the distress in her voice and body language were clear.

The worker then spoke with the physician privately. The physician informed the worker that examination of VA revealed bruising and abrasions to the labia consistent with ongoing forced penetration, noting that the injuries appeared in various stages of healing. The physician estimated that some of the injuries occurred as recently as this week, suggesting continued assault.

The APS worker also spoke briefly with VA's adult son, who confirmed that he had suspected sexual abuse in the past and tried to intervene when he was present. The son acknowledged he had not reported the incidents due to discomfort and fear of family conflict, and he expressed feeling conflicted about how to protect his mother.

The VA was visibly fearful at the thought of returning home to the AP and repeatedly said she did not feel safe around him. She clutched the worker's hand and asked if she could stay at the clinic "just for tonight."

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 3

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Melissa Ortiz

- Age: 22
- Race: Hispanic
- Gender: Female
- Physical location: 309 Balsam Ave. NW, Cass Lake, MN 56633, Cass Co.

Person Alleged Responsible: Veronica Ortiz

- Age: 54
- Race: Hispanic
- Gender: Female
- Physical location: 309 Balsam Ave. NW, Cass Lake, MN 56633, Cass Co.

Reporter: Susanna Morton

- Address: 1107 NW 4th St., Grand Rapids, MN 55744

ADULT MALTREATMENT TAB

Source: Provider

Reporter: Morton, Susanna

Incident:

- Estimated date/time: 7/19/2023
- Location of incident: 309 Balsam Ave. NW, Cass Lake, MN 56633 (VA's home)
- County of incident: Cass

Reporter Requests Initial Disposition: Yes

VICTIM INFORMATION TAB

Alleged Victim: Ortiz, Melissa

Facility/Provider Information: Happy Home Care

VA Provider Name: N/A

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: No

Disabilities: developmentally disabled

Needs Assistance: unable to protect self from abuse/neglect/financial exploitation

Receives Services: home health agency, mental health clinic/center

Diagnosis if Known: developmental disability

DESCRIPTION OF INCIDENT TAB

The reporter is concerned about some of the things they heard and saw while visiting the VA's home.

There is a heavy padlock on the outside of the VA's bedroom door. The reporter questioned whether this is allowed because there is no documentation that this type of restriction has been approved by the VA's medical team. The VA told the reporter that every morning, the AP locks the VA in the VA's bedroom for hours until the AP gets home from work at lunchtime. The VA also told the reporter the VA does not take their pills in the morning anymore because their parents leave early for work. The reporter stated that they have not noticed a behavior change that would indicate the VA was off their medication.

When the reporter asked the AP about the padlock, the AP denied that it is ever used and said they give the VA their medications in the evenings because of the AP's new work schedule.

ALLEGATIONS TAB

Alleged perpetrator name: Ortiz, Veronica

Alleged perpetrator description: N/A

Nature of Allegation

- Physical abuse—unreasonable confinement, involuntary seclusion
- Caregiver neglect—medication

IMPACT/EFFECT ON VA TAB

Unknown

ROLES TAB

- Ortiz, Veronica: Alleged perpetrator
- Ortiz, Veronica: Mother

- Ortiz, Melissa: Alleged victim
- Mortin, Susanna: Reporter
- Mortin, Susanna: Home health nurse

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: other—VA lives with abusive mother

Notification Made by Reporter: N/A

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

The APS worker conducted an unannounced home visit to assess the reported concerns. The AP answered the door and appeared guarded but allowed the worker in, stating curtly that “everything here is fine.”

The worker requested to see the VA, and the AP hesitated before leading the worker down a hallway to a closed bedroom door. On the outside of the bedroom door, the worker observed a large, heavy-duty padlock affixed to the frame, consistent with the reporter’s description. The AP quickly interjected that “we don’t even use that thing; it’s just left over from when we needed to keep the dog out.” When the worker entered the bedroom, the VA was seated on the edge of the bed, dressed in pajama pants and a sweatshirt. The VA appeared freshly showered, with damp hair and clean clothes. She greeted the worker, but her affect was subdued, and she avoided eye contact with the AP.

The worker asked to speak with the VA privately, and the AP reluctantly stepped out of the room. Once alone, the VA’s demeanor became more emotional. She lowered her voice and shared with the worker that the AP locks her in the room every morning before work. She stated, “They say it’s to keep me safe, but I don’t feel safe being trapped in here.” The VA described being left alone in the room for hours each day, saying she feels “like a prisoner” and has no way to leave until the AP returns home for lunch. She expressed significant distress about not being able to access the bathroom when locked in, saying she tries to “hold it” and sometimes has accidents. When asked about her medications, the VA informed the worker that she now takes her anti-depressants at night instead of in the morning, because the AP no longer has time to give it to her in the morning. She reported feeling no worsening of symptoms since this switch. At the end of the conversation, she expressed fear about angering the AP by talking to the worker and repeatedly asked if the AP would “find out” what she said.

The APS worker then returned to the living room and questioned the AP about the lock. The AP reiterated that it was “never used” and claimed they administer all medications in the evening now because of their work schedule. The AP’s demeanor was defensive and dismissive of the VA’s statements, and the AP ended the interview with the worker quickly, stating, “I have answered all of your questions and I have nothing more to say.”

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 4

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Rusty Cooper

- Age: 70
- Race: Black/African American
- Gender: Male
- Physical location: 324 9th St. N, Cannon Falls, MN 55009, Goodhue Co.

Reporter: Max Collins

- Address: 322 9th St. N, Cannon Falls, MN 55009, Goodhue Co.

ADULT MALTREATMENT TAB

Source: Neighbor

Reporter: Collins, Max

Incident:

- Estimated date/time: 7/15/2023, 4:15 p.m.
- Location of incident: 324 9th St. N, Cannon Falls, MN 55009 (VA's home)
- County of incident: Goodhue

Reporter Requests Initial Disposition: No

VICTIM INFORMATION TAB

Alleged Victim: Cooper, Rusty

Facility/Provider Information: N/A

VA Provider Name: N/A

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: No

Disabilities: Impaired reasoning or judgment

Needs Assistance: Food, health care, hygiene, safety, supervision, toileting

Receives Services: Unknown

Diagnosis if Known: N/A

DESCRIPTION OF INCIDENT TAB

The reporter noticed the VA's hygiene is declining and that the VA is no longer as social as they used to be.

The reporter reported that they see the VA sitting on the VA's patio every day, and for the past two weeks, the VA has been wearing the same outfit and does not appear to have showered. The reporter said that they visited the VA's home this evening to check on the VA and bring them dinner.

The reporter said the home was disgusting. There was liquid on the floor that the reporter believed to be urine, and hand towels in the bathroom were covered in feces. The reporter said the floor was covered in "dirt and stuff," making it difficult to navigate through the home. The bed had no bedding, and the mattress was covered in unidentified stains. The reporter stated that the VA has repeatedly left their stove on overnight because they forget to turn it off. Recently, the stove caught fire after the VA forgot to turn it off. The stove is now completely burnt on the top and non-functional.

The VA was in the same clothing they had been wearing for the past two weeks, and it was covered in stains and smelled bad. The reporter noticed rashes on both of the VA's arms. The VA appeared to be confused when having conversations. The reporter stated that the VA said dinner delivery was unnecessary and that they could go eat at a restaurant in town because the VA had bought it, which is untrue. When the reporter questioned the VA about this, the VA became angry and insisted that they were the restaurant's new owner. The reporter does not believe the VA can take care of themselves. The reporter believes someone needs to come in and provide care for the VA immediately.

ALLEGATIONS TAB

Nature of Allegation

- Self-Neglect—services essential to welfare or safety of the person
- Self-Neglect—clothing
- Self-Neglect—health care
- Self-Neglect—food
- Self-Neglect—supervision

IMPACT/EFFECT ON VA TAB

Worsening Physical or Mental Health

- *Describe the effect to physical or mental health:* VA wears same clothes for two weeks with stains, lack of basic hygiene, rashes on arms, statements do not make sense with reality

Environmental hazard

- *Describe specific hazard:* urine on floor, feces on bathroom towels, floor covered in dirt making it hard to navigate, mattress has no bedding and covered in stains, stove caught fire in home
- *Effect on VA:* VA has poor hygiene, rashes on arms

Lack of reasonable or necessary clothing

- *Effect on VA:* VA wears the same clothes for two weeks with stains

VA's behavior creates a health or safety risk for the VA

- *Describe hazard:* VA leaves stove on and it caught fire
- *Duration:* repeatedly
- *Harm:* stove caught fire in home
- *Impact on VA:* no functioning stove to cook meals

ROLES TAB

- Cooper, Rusty: Alleged perpetrator
- Cooper, Rusty: Alleged victim
- Collins, Max: Neighbor
- Collins, Max: Reporter

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: Environmental hazards

Notification Made by Reporter: N/A

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

The APS worker arrived at the VA's home and found the front door unlocked. The VA was seated on a plastic chair on the patio, wearing heavily soiled pants and a short-sleeved shirt, matching the description of the clothing the reporter said he'd been wearing for the past two weeks. Both articles of clothing were stained with what appeared to be food, dirt, and bodily fluids, and smelled strongly of urine. The VA's hair was uncombed and greasy, and he smelled of body odor. The worker noted visible reddish rashes and skin irritation on both forearms, with evidence of scratching.

When greeted by the worker, the VA appeared momentarily confused, asking, "Are you here from the restaurant?" When the worker clarified her purpose for the visit, saying she was here to check on the VA and ensure he was doing okay, the VA became defensive and stated, "I am doing fine. I don't need any help." The VA demonstrated poor insight into his circumstances, insisting that he was financially independent and able to care for himself despite observable evidence to the contrary. He informed the worker that he owned a restaurant in town but could not provide any further details about this when asked. He also informed the worker that he showers daily, although his appearance clearly indicated otherwise. The VA was irritable throughout the conversation and raised his voice when the worker gently questioned him about the condition of the home and his hygiene, stating he was "just fine" and accusing the worker of "interfering with his life."

The adult did agree to let the worker inside his home for a brief look. Upon entering the home, the worker noted that the home was in significant disarray. The flooring throughout the living room and kitchen was sticky with an unknown liquid and tracked-in debris. The bathroom contained towels visibly stained with feces that were draped over the sink and tub edge, and the bedroom floor was strewn with feces-stained towels. The mattress in the bedroom was bare and had several large stains. There were no clean sheets or blankets seen anywhere in the home. Both the bathroom and bedroom smelled strongly of urine and feces. The worker observed the kitchen stove to be scorched and nonfunctional, with blackened burner plates and melted control knobs, consistent with a small fire. The burnt stove was piled high with books, papers, and articles of clothing. VA did not appear to understand or acknowledge that the stove was now damaged and unusable, saying simply, "It's fine, I'll cook later. Tonight, I'm eating at my restaurant"

The worker observed that VA's demeanor fluctuated between confusion and frustration. His speech was wandering and hard to follow at times. He appeared unable to appreciate the hazards present in his environment and unwilling to accept assistance, repeatedly insisting he could care for himself and does not need anybody to help him.

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 5

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Rita Welch

- Age: Middle-aged
- Race: Caucasian
- Gender: Female
- Physical location: 858 Jonathan Dr., Apple Valley, MN 55124, Dakota Co.

Person Alleged Responsible: Alexis Lopez

- Age: 48
- Race: Hispanic
- Gender: Female
- Physical location: 13262 Huntington Terrace, Apple Valley, MN 55124, Dakota Co.

Reporter: Tasha Olson

- Address: 901 Rushmore Dr., Burnsville, MN 55306, Dakota Co.

ADULT MALTREATMENT TAB

Source: friend

Reporter: Olson, Tasha

Incident:

- Estimated date/time: 7/1/2023, 12:15 p.m.
- Location of incident: 858 Jonathan Dr., Apple Valley, MN 55124
- County of incident: Dakota

Reporter Requests Initial Disposition: No

VICTIM INFORMATION TAB

Alleged Victim: Welch, Rita

Facility/Provider Information: N/A

VA Provider Name: N/A

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: No

Disabilities: Traumatic brain injury

Needs Assistance: Don't know

Receives Services: Personal care assistance

Diagnosis if Known: N/A

DESCRIPTION OF INCIDENT TAB

The reporter said they had lunch plans with the VA, but when the reporter went to the VA's house, the AP answered the door and said the VA did not feel like having visitors. The reporter said that during this exchange, the reporter heard the VA in the background telling the AP to let the reporter in, but the AP acted like they did not hear anything.

The reporter did not want to cause a scene, so they decided to return home and call the VA on their cell phone. The reporter reported that the AP answered the phone, which was strange because the VA usually answers their own phone. The AP again told the reporter that the VA did not feel like speaking to anyone and asked the reporter not to bother the VA again.

When the reporter went to the VA's house the next morning before the AP arrived, the VA opened the door and invited the reporter in immediately. The reporter said the VA apologized for the situation the previous day and said whenever the VA makes plans, the AP frequently does things like that because the AP does not want to deal with it.

The VA said they rarely see friends or family anymore because the AP will not allow it. The reporter said that the VA is worried they will start to lose friendships because of the AP's behavior, but the VA is afraid to confront the AP about it.

ALLEGATIONS TAB

Alleged perpetrator name: Lopez, Alexis

Alleged perpetrator description: 5'6" female with glasses and black hair

Nature of Allegation: Emotional or Mental Abuse—forced separation of the VA from another person against the wishes of the VA, or legal representative's wishes

IMPACT/EFFECT ON VA TAB

Other impact, harm, or risk experienced by VA as a result of alleged maltreatment

- *Describe behavior:* AP is not allowing the VA to have any contact with friends and family, and the VA is worried they will lose friends.

ROLES TAB

- Welch, Rita: Alleged victim
- Olson, Tasha: Friend
- Olson, Tasha: Reporter
- Lopez, Alexis: Alleged perpetrator
- Lopez, Alexis: Personal care assistant

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: N/A

Notification Made by Reporter: N/A

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

Upon arriving at the VA's home, the worker was greeted at the door by the VA, who opened the door quickly and appeared relieved to see the worker. The worker noted that the VA's hands were trembling slightly, and the VA repeatedly looked toward the driveway as though nervous about someone else arriving. The VA invited the worker in and was eager to talk, lowering their voice and stating, "I don't have much time before they get back."

The home itself appeared clean and orderly, with no obvious hazards, clutter, or environmental concerns. However, the worker noted that the home was unusually warm despite the outside temperature being mild. The thermostat inside read 84°F, and all the windows were shut. When asked, the VA explained that the AP does not allow the air conditioning to be used, claiming it's too expensive, and has instructed the VA not to open the windows under any circumstances. The worker observed several ceiling fans throughout the home that were running. The VA was dressed in clean shorts and a clean T-shirt, and her hair was neatly pulled back. The VA offered the worker a seat on the couch, and the VA sat on the edge of their chair, appearing anxious. The VA began to cry quietly while describing their situation. The VA stated that the AP routinely prevents the VA from keeping appointments with friends or family and answers the VA's phone to keep others from reaching them. The VA recounted the prior day's incident, when the AP ignored the VA's own request to allow the reporter into the home and

instead told the visitor to leave. The VA said, "They just act like I'm not even saying anything. They don't let me have visitors because they don't want to 'deal with it.'"

As the conversation continued, the VA disclosed that the AP has begun physically restraining them when they attempt to leave the house to meet friends or answer the door. The VA stated, "Last week, I tried to go outside when my friend came by, and [the AP] grabbed my arm so hard it left a bruise. Then they pushed me back into the chair and stood in front of me until my friend went away." The VA rolled up their sleeve and showed the worker faint bruising along the upper arm consistent with being gripped tightly. The VA described another incident in which the AP reportedly held the VA's wrists behind their back to prevent them from opening the door for a visitor. The VA described the AP's behavior as controlling and physically intimidating, saying, "They tell me to just sit and stay quiet. I'm afraid of what they'll do next time if I don't listen."

The VA expressed fear of the AP, saying, "I try not to make them mad. But I'm scared it's going to get worse. I already feel like a prisoner in my own home." The VA verbalized concern about losing friendships and further isolation but said they felt helpless to stop the AP's behavior, stating, "I don't know what to do. They get angry if I even try to stand up for myself. I am worried things will escalate."

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 6

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Alyssa Curtis

- Age: 30
- Race: Caucasian
- Gender: Female
- Physical location: 345 N Brown Rd., Long Lake, MN 55356, Hennepin Co.
- Other address: 3411 Larchwood Dr., Minnetonka, MN 55345, Hennepin Co.

Person Alleged Responsible: Jim Richards

- Age: 58
- Race: Caucasian
- Gender: Male
- Physical location: 3411 Larchwood Dr., Minnetonka, MN 55345, Hennepin Co.

Reporter: Mary Miller

- Address: 345 N Brown Rd., Long Lake, MN 55356, Hennepin Co.

ADULT MALTREATMENT TAB

Source: Provider

Reporter: Miller, Mary

Incident:

- Estimated date/time: 6/30/2023, 3:15 p.m.
- Location of incident: 345 N Brown Rd., Long Lake, MN 55356
- County of incident: Hennepin

Reporter requests initial disposition: Yes

VICTIM INFORMATION TAB

Alleged Victim: Curtis, Alyssa

Facility/Provider Information: 345 N Brown Rd., Long Lake, MN 55356

VA Provider Name: Long Lake Adult Foster Care

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: No

Disabilities: Developmentally disabled

Needs Assistance: Clothing, financial management, food, health care, safety, shelter, supervision, unable to protect self from abuse/neglect/financial exploitation

Receives Services: Adult foster care, mental health clinic

Diagnosis if Known: N/A

DESCRIPTION OF INCIDENT TAB

It was reported last night and confirmed today that the VA's stepfather (AP) sent the VA pictures of the AP's penis and told the VA that they would "really hurt" the VA if they showed the pictures to anyone else. The VA lives at an adult foster care home and showed the pictures to facility staff.

The VA also reported that the AP has taken nude pictures of the VA and forces the VA to watch pornographic videos with the AP. When the VA told their mother/guardian, the mother told the VA not to tell anyone because the police would take the VA and the AP to jail.

The VA is planning to go to their mother's and AP's home at the end of this week, six days from now. The facility refused to transport the VA, but the mother and AP are planning to pick the VA up and have asked for the VA's medications to be packed. The VA wants to go with them but is worried that they will get in trouble if their mother and AP find out the VA showed the pictures to facility staff.

ALLEGATIONS TAB

Alleged Perpetrator Name: Richards, Jim

Alleged Perpetrator Description: 6'3" male with short blonde hair and glasses

Nature of Allegation: Sexual abuse

IMPACT/EFFECT ON VA TAB

Other impact, harm, or risk experienced by VA as a result of alleged maltreatment

- *Describe behavior:* VA is worried they will get in trouble for showing the nude pictures to facility staff. The VA is also expected to be picked up by the AP in six days and there is no support to keep the VA safe.

ROLES TAB

- Miller, Mary: Reporter
- Miller, Mary: Facility provider
- Curtis, Alyssa: Alleged victim
- Richards, Jim: Alleged perpetrator
- Richards, Jim: Stepfather
- Richards, Jamie: Mother

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: N/A

Notification Made by Reporter: 911

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

The assigned APS worker made a scheduled visit to the adult foster care home to complete a face-to-face visit with the VA. Upon arriving at the foster care home, the APS worker met with the provider, who informed the worker that the adult is diagnosed with Down Syndrome, and also provided suggestions on how to best engage the VA. The provider then guided the worker to the VA's private bedroom.

The worker noticed that the VA's bedroom was very tidy and decorated with stuffed animals, and photo collages lined the walls of the room. The VA smiled shyly when the provider introduced the worker and then turned away while holding a small stuffed teddy bear. The provider left the worker alone with the VA to complete the interview and stated that she would be returning to her office and available to assist, if needed.

The worker attempted to engage the VA in a conversation about the pictures on her wall. The VA responded happily and told the worker how she loves to take photos and use her Polaroid camera. She then turned away from the worker and quietly said, "But sometimes I get pictures that I'm not allowed to talk about." Her voice became louder as she exclaimed, "I don't like those pictures, and I want them to stop!"

The worker noticed a change in the VA's overall disposition and that her grip on the stuffed animal had changed from casually holding the item to tightly clinging to the stuffed animal by its head. When the worker asked the VA what was wrong, she began to cry and told the worker more details about the photos she received from her stepfather. She told the worker that her stepfather will send her photos of his "private parts" and tells her that it's their "special secret." She told the worker that she does not like

getting these photos and they make her afraid. She shared that she was afraid to tell her mother about the pictures because the AP might hurt her or hurt her mom if she finds out about their “secret photos.”

She then added, “I don’t like those pictures, and I don’t like him! I don’t want to go with my mom because she will leave me with that mean man. When she leaves, he makes me watch movies with him—but they’re not good movies like the Care Bears—they’re bad movies with naked people who jump all over each other. I cry when he makes me watch those movies and ask him to stop playing them, but he won’t listen. I hate those movies and I hate those pictures and I wish they would all go away!”

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 7

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Jim Andrews

- Age: 90
- Race: Caucasian
- Gender: Male
- Physical location: 825 9th Ave. S #134, St. Cloud, MN 56301, Stearns Co.

Person Alleged Responsible: Andrea Unknown

- Age: 50s
- Race: Caucasian
- Gender: Female
- Physical location: Unknown

Reporter: Alice Stevens

- Address: 825 9th Ave. S #136, St. Cloud, MN 56301, Stearns Co.

ADULT MALTREATMENT TAB

Source: Neighbor

Reporter: Stevens, Alice

Incident:

- Estimated date/time: 6/4/2023, 1:15 p.m.
- Location of incident: 825 9th Ave. S #134, St. Cloud, MN 56301
- County of incident: Stearns

Reporter requests initial disposition: Yes

VICTIM INFORMATION TAB

Alleged Victim: Andrews, Jim

Facility/Provider Information: 110 2nd St. S, Waite Park, MN 56387

VA Provider Name: Open Hearts Homecare Services

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: Yes

Disabilities: Frailty of aging, impaired memory

Needs Assistance: Food, health care, safety, supervision, unable to protect self from abuse/neglect/financial exploitation

Receives Services: Personal care assistance, crisis respite

Diagnosis if Known: dementia

DESCRIPTION OF INCIDENT TAB

The reporter called to report that the 90-year-old VA, who lives in the apartment next door, appears to be the victim of some type of physical abuse. When the reporter visited VA to return mail that was accidentally sent to the reporter, they noticed the VA's arms were covered in bruises, and there was an open abrasion on the VA's left cheek.

When the reporter asked the VA about the cuts and bruises, he told the reporter they were struck repeatedly by one of their personal care assistants (PCAs) last night because the VA left a gas burner on and unattended. The AP told VA that if they ever tried to use the stove by themselves again, the AP would "make them real sorry" and would not hesitate to beat the VA again.

VA said the AP sometimes makes the VA skip dinner if the VA does something wrong, and the VA has previously gone more than two days without eating when being punished. The AP locks the food away and blocks the VA from entering the kitchen. The VA is not allowed to tell the other PCA.

This is the 16th call from the reporter in the past 12 days. The reporter, who has a long pattern of reporting false information about neighbors, has already reported about VA several times this week, with different stories each time. An APS investigator has contacted the VA and the VA's family, as well as the VA's PCA agency. The VA has not had any injuries when APS workers have gone to the VA's home.

ALLEGATIONS TAB

Alleged Perpetrator Name: Unknown, Andrea

Alleged Perpetrator Description: 5'5" female with black hair, average build

Nature of Allegation

- Physical abuse—hitting or punching
- Emotional or mental abuse—oral communication
- Caregiver neglect—supervision
- Caregiver neglect—food

IMPACT/EFFECT ON VA TAB

Hospitalization or medical treatment required

- Diagnosis or symptoms: several bruises and open abrasion to left cheek
- Admission or treatment date: N/A
- Name of hospital or provider: N/A
- Effect on VA: physical injury

Physical, emotional, mental, or sexual injury

- Identify and describe the injury: several bruises and open abrasion to left cheek; VA reports being struck repeatedly by AP.
- Treatment received: No
- Name of medical provider: N/A

Lack of reasonable or necessary food

- Effect on VA: VA reports going more than two days without eating after AP locks food away; sometimes is not allowed to eat dinner

ROLES TAB

- Andrews, Jim: Alleged victim
- Stevens, Alice: Reporter
- Stevens, Alice: Neighbor
- Unknown, Andrea: Alleged perpetrator
- Unknown, Andrea: Personal care assistant

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: Other—VA cared for by AP

Notification Made by Reporter: N/A

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

Before visiting the VA, the caseworker reviewed the VA's case files to get a better understanding of the previous allegations concerning the adult. The worker was able to review the 16 reports coming from Mr. Andrews's neighbor and found that in some instances, the reporter was calling twice, if not three times in one day, to report her concerns regarding Mr. Andrews.

After reviewing the files, the worker placed a call to Ms. Alice Stephens, the reporter of this most recent allegation. Ms. Stephens thanked the worker for calling and said, "Finally, someone is listening to me! Every time I've called, it seemed like no one was ever going to come!" Ms. Stephens confirmed the details of her report. She also added that no one comes to see Jim other than the personal care assistants and that if she wasn't his neighbor, he would be a "lost soul."

The reporter informed Mr. Andrews of her most recent report to APS, so Mr. Andrews was expecting a visit. He apologized to the caseworker and said, "You really don't need to be worried about me, but it is nice to get a visitor." He was friendly, alert, and eager to resolve the situation. Mr. Andrews seemed far less alarmed than Ms. Stephens. He welcomed the worker into his apartment and invited the worker to take a seat. The home was a little cluttered, with stacks of mail on a side table and stacked boxes of medical supplies in a few corners of the room, but the walkways were clear and the kitchen and living room were clean and otherwise well managed.

After getting settled in his own chair, Mr. Andrews told the worker that he couldn't remember the last time he'd spoken with Ms. Andrews, but that she is always "looking out for him" and sometimes reminds him to get his mail, especially when his mailbox gets a little too full. Mr. Andrews also shared with the worker that his days are uneventful and that he doesn't have many visitors other than his personal care assistants and Ms. Stephens, who he usually chats with on his doorstep. He mentions his PCA Andrea and shared with the worker that she has been his assistant for years, though she "isn't as good as she used to be, and sometimes, she's downright mean."

The worker asked Mr. Andrews to tell him more about Andrea's behavior. Mr. Andrews stated that Andrea started working as his PCA about 10, maybe 12 years ago and used to be his only PCA, but that another worker now comes every other visit. He also told the worker that Andrea can be bossy and sometimes shouts her instructions to Mr. Andrews when he isn't wearing his hearing aids or forgets to charge them. He suggested that maybe Ms. Stephens hears the yelling and thinks that something is wrong but assures the worker that he is not afraid of Andrea and that she has never attempted to physically harm him. The worker then asked Mr. Andrews if he has ever been hit by Andrea or had any bruises as a result of her care. Mr. Andrews told the worker that he's never been hurt by Andrea and that the only marks that might look like bruises or cuts are the liver spots on his face and arms or the purple spots he gets due to his weak veins, and that he sometimes cuts his face while attempting to shave (Mr. Andrews had trouble remembering the word for "shave" but repeated a shaving motion until he was able to think of the proper word).

When asked about food, Mr. Andrews told the worker that his PCAs sometimes help him prepare meals because he can be forgetful when it comes to turning off the stove. He then told the worker about a time that he tried to make oatmeal on the stove and forgot to turn off the burner. By his account, it was Andrea who came to his apartment that morning and realized the gas had been left on. He said she

opened all of the doors and windows and told him, “Don’t ever do that again—you could have really been hurt—that could have caused an explosion!”

Andrea arrived at the VA’s residence while the worker was completing the face-to-face visit and introduced herself to the caseworker. Upon learning that another report had been made, her face became visibly concerned. Andrea stated that she has been working with Mr. Andrews for years but isn’t as young or strong as she used to be and isn’t able to do a lot of the physical care for Mr. Andrews, so her company has started substituting her visits with another PCA who can care for Mr. Andrews’s physical needs. She explained that she often prepares meals for the VA and only brings two at a time so that Mr. Andrews doesn’t eat them all in one day, as he often forgets having eaten and will “eat everything in sight if you let him.” She went on to show the caseworker the VA’s paperwork from meals on wheels, which provides him two meals and two small snacks (per day) a few times each week but added that Mr. Andrews doesn’t like to eat these meals as they aren’t seasoned to his liking and will say, “You must want me to starve!” when presented with those meals. Andrea also encouraged the worker to speak with her supervisor and provided their contact information.

Following the visit, the caseworker made a collateral contact with the PCA agency to inquire about Mr. Andrews’s assigned workers and the care he has received from Andrea. Without disclosing any confidential information, Andrea’s manager confirmed that she has worked with their agency for more than 20 years and is one of their best workers, with an immaculate work and overall performance history. The manager did confirm that Andrea has started to transition into more of a supervisory role as she is no longer able to meet many of the physical demands of her job. The manager also confirmed knowledge of the previous reports to APS and verified that their office has worked with the VA’s family to follow up on each report received and that neither the family nor the agency has observed any bruises or injuries to the VA.

STOP. COMPLETE THE SAFETY ASSESSMENT.

VIGNETTE 8

FOUND IN THE PERSON NODES IN THE TREE

Adult Suspected to Be Vulnerable: Sue Williamson

- Age: 80
- Race: Caucasian
- Gender: Female
- Physical location: 458 Edmun Ave. W, St. Paul, MN 55103, Ramsey Co.

Person Alleged Responsible: Eric Williamson

- Age: 80s
- Race: Caucasian
- Gender: Male
- Physical location: 458 Edmun Ave. W, St. Paul, MN 55103, Ramsey Co.

Reporter: Latroya Jones

- Address: 3833 11th Ave. S, Minneapolis, MN 55407

ADULT MALTREATMENT TAB

Source: Provider

Reporter: Jones, Latroya

Incident

- Estimated date/time: 7/15/2023, 9:45 a.m.
- Location of incident: 458 Edmun Ave. W, St Paul, MN 55103 (VA's home)
- County of incident: Ramsey

Reporter requests initial disposition: No

VICTIM INFORMATION TAB

Alleged Victim: Williamson, Sue

Facility/Provider Information: N/A

VA Provider Name: N/A

VA Deceased: No

VA Has Experienced Serious Injury as a Result of Maltreatment: No

Disabilities: Impaired memory, impaired reasoning or judgment, frailty of aging

Needs Assistance: Financial management, food, health care, hygiene, safety, supervision, toileting, unable to protect self from abuse/neglect/financial exploitation

Receives Services: Mental health clinic/center, home- and community-based services

Diagnosis if Known: Potentially dementia

DESCRIPTION OF INCIDENT TAB

The reporter has concerns about a VA and the VA's spouse. VA cannot take their medications the way they are supposed to be taken and often forgets they even have medications. VA no longer bathes or showers because they are worried about falling in the bathroom, but the VA has no other way to wash themselves. VA has reported falling in the tub several times and has been injured in the past. VA told reporter that the VA's spouse refuses to supervise the VA in the bathroom. The reporter said that the VA "smells awful" and reported an infection "in a place I will not talk about" from the lack of bathing and the VA's issues with incontinence.

The reporter said that the other day, they had to explain to the VA and their spouse what an electricity bill was and how to pay it because their electricity was turned off. The reporter helped get the electricity turned back on. The reporter said the VA and their spouse do not understand why it is important to keep the VA's oxygen tank turned on, or to have VA take their medications. When the reporter was there, the VA forgot they were diabetic even though they had this diagnosis for years. The VA and their spouse receive some services from Catholic Charities, which assists with housekeeping and groceries.

The spouse is currently caring for VA; however, the reporter said it is scary that no one is taking care of both of them. The reporter believes the VA has dementia. Today, the VA did not know the day of the week and did not know that they were on oxygen.

When the reporter asked the VA about their medication box, the VA replied that they did not have one. The VA's spouse went and got it, and it was empty. The box is prefilled at the pharmacy, and the reporter thinks the VA must have doubled up on their medications and asked the VA's spouse to go to the pharmacy and get it filled for the week. The spouse told the reporter that they would get it on Wednesday. The reporter stated that the spouse did not understand that this meant the VA would go two days without any medications.

The reporter said the couple has six children, and only one lives in Minnesota. Last week, VA refused to give reporter the VA's daughter's name, saying the daughter did not need to know any of this. Today, the VA gave the daughter's name and number to the reporter, but the reporter could not reach the daughter. The reporter cannot return to the home for at least a week.

ALLEGATIONS TAB

Alleged Perpetrator Name: Williamson, Eric

Alleged Perpetrator Description:

Nature of Allegation

- Caregiver neglect—health care
- Caregiver neglect—medication
- Caregiver neglect - supervision

IMPACT/EFFECT ON VA TAB

Lack of necessary health care, services, or supervision

- **Describe:** VA has signs of poor hygiene, requires supervision while bathing to prevent injury, has an untreated infection, and is not maintaining oxygen and medication as prescribed
- **Why is VA not receiving:** Unknown
- **Effect on VA:** VA has an infection, impaired memory and judgment
- **Date of service loss:** N/A

VA's behavior creates a health or safety risk for the VA

- **Describe hazard:** VA not taking prescribed medication; not using oxygen as intended; unable to pay electricity bill, causing electricity to be turned off; spouse doesn't help the VA meet their needs
- **Duration:** about a week
- **Harm:** basic needs are not met
- **Impact on VA:** infection, lack of utilities, lack of prescribed medication

ROLES TAB

- Jones, Latroya: Reporter
- Jones, Latroya: Provider
- Williamson, Sue: Alleged victim
- Williamson, Sue: Alleged perpetrator
- Williamson, Eric: Spouse

SAFETY TAB

Has Action Been Taken to Protect the Vulnerable Adult From Further Harm: No

Environmental Safety: N/A

Notification Made by Reporter: N/A

ASSESSMENT RESPONSE AND WORKER INITIAL FACE-TO-FACE CONTACT DETAILS

The APS worker made an unannounced visit to the Williamson residence. Mr. Williamson answered the door and asked who the worker was and why he was there. The worker introduced himself and asked Mr. Williamson if they could sit and talk more privately. Upon entering the residence, the worker noticed that the home was somewhat cluttered with several stacks of mail, papers and newspapers on the coffee table but was otherwise clean with accessible walkways and open floor space. The laminate floors and carpets were clear of any trash or debris, but there was a strong odor of urine present as soon as the worker entered the front door.

The APS worker informed the VA's spouse of the report that was received and asked Mr. Williamson how things have been going for him and his wife. Mr. Williamson explained to the worker that his wife is not oriented most of the time, has tried to wander off, becomes verbally combative, and is not able to care for herself. He then added that while he has been trying to care for her on his own, he is realizing that that he may not be able to continue doing so because of his age and his own set of medical challenges. Mr. Williamson then stated, "On top of all the health issues she has going on, she swings at me whenever I try to help her—she literally refuses my attempts to help, but she can't do much on her own. I want to help her, but I feel like my hands are tied!"

Mr. Williamson guided the worker to VA's bedroom, which was not far from the entry to the home. Mrs. Williamson was awake and lying in bed. The worker introduced himself and attempted to engage Mrs. Williamson in a conversation. At the time of the visit, Mrs. Williamson appeared to be dazed and was somewhat confused and demonstrated memory issues. Throughout the visit, she repeated the worker's name as if she was trying to remember it. There were prescription medications in a medicine box on a table next to her bed, but she could not identify them, explain what they were prescribed for, or confirm whether she had taken any of the medications that day, despite that day's dose being absent from the medicine organizer. The APS worker observed a disconnected oxygen tank next to the VA's bed along with a mask that was still in its sealed packaging. Both items appeared to be unused.

When the worker surveyed Mrs. Williamson's bedroom, he noticed a small pile of soiled adult diapers in a corner near the bed. Mrs. Williams was dressed appropriately, though her hair was a bit disheveled, there were stains on her clothing, and she smelled of urine. The worker asked Mrs. Williamson when she had last taken a shower, to which she replied, "Oh, maybe yesterday. I fell and hurt myself bad one time—I don't want to get hurt again."

The worker also attempted to discuss financial management practices with the couple. When asked about finances, Mr. Williamson reported that they are financially stable. Mr. Williamson explained that he receives \$2,400 per month from his federal pension and that with Mrs. Williamson's retirement, they receive a combined income of \$4,000 per month. Mr. Williamson added that he forgot to pay one of their bills recently, but said, "We got help taking care of that—so we're fine now." The worker asked Mr. Williamson who manages their bills and expenses, and he responded, "I do. Like I said, we had some issues recently, but I usually remember to pay our bills and our daughter Samantha comes every other

month or so to check on us.” Mrs. Williamson was largely silent while Mr. Williamson answered the worker’s questions and would look off into the distance or stare blankly at the worker or Mr. Williamson.

Both adults receive assistance from Catholic Charities (grocery assistance and limited homemaker assistance). According to Mr. Williamson, his insurance recently obtained a caregiver for four hours a day. He stated that he pays the same caregiver privately for an additional three hours and that the caregiver is in their home from 6:00 a.m. to 1:00 p.m. The APS worker informed Mr. Williamson that he and his spouse might benefit from 24-hour care; however, Mr. Williamson said he cannot afford it. When the worker went on to explain some of the additional benefits of assisted living, Mr. Williamson agreed that they could use “a little more help” would rather be in their home with the care they are receiving.

STOP. COMPLETE THE SAFETY ASSESSMENT.