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# SDM® APS INTAKE ASSESSMENT IRR FINDINGS

## MINNESOTA DEPARTMENT OF HUMAN SERVICES

December 2023



## ABOUT EVIDENT CHANGE

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# INTRODUCTION

Minnesota Department of Human Services (DHS) Adult Protection Services (APS) is collaborating with Evident Change to update their Structured Decision Making® (SDM) intake assessment for APS.

The purpose of inter-rater reliability (IRR) testing is to determine whether the assessment will help workers to consistently determine whether allegations of neglect, self-neglect, or maltreatment regarding a vulnerable adult made during a report meet the threshold for an APS response and if so, how quickly. IRR testing helps to identify specific parts of the tool that may require a revision to improve clarity or areas for targeted training prior to implementation.

IRR testing took place September 13–27, 2023. This report summarizes the results and provides guidance for APS to support the intake assessment's implementation.

# WHAT IS INTER-RATER RELIABILITY?

IRR is a measure of consistency. It determines the extent to which different raters will arrive at the same conclusion when presented with the same information. IRR is critical because in its absence, service recommendations for vulnerable adults may differ according to which worker performed the assessment.

Evident Change uses percent agreement as a measure to evaluate IRR because it is straightforward and it clearly demonstrates how often workers arrive at the same decision. Percent agreement is calculated by dividing the number of agreements for an item (i.e., how often participants arrived at the same response) by the number of responses for that item.

In particular, Evident Change considers the following.

- **Overall percent agreement.** For each assessment item, the total number of agreements divided by the total number of responses.
- **Minimum percent agreement.** For each assessment item, the lowest percent agreement achieved on any vignette.
- **Maximum percent agreement.** For each assessment item, the highest percent agreement achieved on any vignette.

If the percent agreement falls below 75%, Evident Change recommends addressing the inconsistencies by revising definitions or targeting training to certain areas of the assessment. In Tables 1–4, shaded cells indicate agreement below 75%.

# METHODS

For the IRR test, 75 workers, supervisors, and DHS project staff representing 40 counties across Minnesota volunteered to participate in testing. During the three-week IRR test, 54 participants (excluding DHS project staff) completed 812 unique tests. DHS project staff completed 89 tests of the intake item definitions. Because the DHS project staff testing method differed from county participant methods, they were excluded from the primary data set and used for a separate analysis.

County IRR participants were assigned to one of two groups. Group A completed the vulnerable adult status section for vignettes 2–8 and 13 while Group B completed the section for vignettes 9–16. Group A completed the allegation and response priority section for vignettes 1, 9–12, and 14–16 while Group B completed these sections for vignettes 1-8. Both groups completed the allegation and response priority section for vignette 1 and completed the vulnerable adult status section for vignette 13. A third group composed of DHS project team members completed the sections on vulnerable adult status, allegations, and response priority for all vignettes.

Six responses were not marked as complete but, upon inspection, were kept in the data as they were both unique (in other words, not duplicate responses from the same participant) and had recorded responses for at least one definition. In addition, 24 responses for vignette 10 were excluded from the screening criteria allegation and response priority analysis because more 50% of respondents indicated that the report should be screened out.

# RESULTS

Minnesota APS intake assessment IRR study results suggest strong overall percent agreement throughout the tool. Participants completed 15 vignettes on average, with more than three quarters completing all 16, with a range of 49 to 53 responses per vignette. Five of the six vulnerable adult status items had overall percent agreement above 82%. All allegation screening criteria items had overall percent agreement above 83% with an average of 94% for all items. Four of the five response priority items had an overall percent agreement above 82%. Two assessment items had an overall percent agreement below 75%.

## SCREENING CRITERIA: VULNERABLE ADULT STATUS

Vulnerable adult status is completed first and used to determine whether the person in the report meets the definition of a vulnerable adult under Minnesota statute. To move to the screening criteria section of the assessment, workers must follow the tool logic to determine eligibility. As a result, an adult may be determined vulnerable (or not vulnerable) prior to completing all six items.

Overall percent agreement was above 75% for five vulnerable adult status items, and the maximum percent agreement was 100% for all six, meaning that for each, at least one vignette had 100% agreement. Item 6 (Unable to determine vulnerability status AND there is still reason to believe the adult is eligible for screening) had an overall percent agreement of 74%. Item 6 is only presented if certain tool logic conditions are met and is a catch-all item when workers believe an adult who does not meet other criteria is eligible for screening. For all six items, minimum percent agreement fell below 75% on at least one vignette, ranging from 50% to 74%. Two items had vignettes with split agreement (50%; Table 1).

**TABLE 1**

**IRR RESULTS**
**SECTION 1, PART A: VULNERABLE ADULT STATUS**

| ELIGIBILITY ITEM | OVERALL % AGREEMENT | MINIMUM % AGREEMENT | MAXIMUM % AGREEMENT |
|---|---|---|---|
| Adult receives personal care assistance (PCA) paid for under the medical assistance program. (N = 404) | 96% | 74% | 100% |
| Adult is participating in a licensed service. (N = 403) | 94% | 54% | 100% |
| Adult is believed to have diagnosis or condition impairing physical, cognitive, or emotional functions. (N = 277) | 82% | 53% | 100% |
| Adult is believed to have impaired ability to complete their own ADLs or IADLs without assistance. (N = 277) | 84% | 57% | 100% |
| Adult is believed to have an impaired ability to protect themself from maltreatment. (N = 194) | 89% | 50% | 100% |
| Unable to determine vulnerability status AND there is still reason to believe the adult is eligible for screening. (N = 108) | 74% | 50% | 100% |

Overall, this section had high inter-rater consistency. Based on a review of the vignettes with lower than 75% agreement for item 2, Evident Change recommends that intake items 1 and 2 be combined into one item. Combining these should reduce confusion on which services or supports fall under each item. Evident Change also recommends using a scenario similar to vignette 13 in training to support use of vulnerable adult status items 3, 4, and 5.

## SCREENING CRITERIA: ALLEGATIONS

The allegation section of the APS intake assessment is composed of six categorical forms of maltreatment, neglect, or self-neglect of a vulnerable adult. These allegation types are further broken down in the SDM intake assessment to provide a more granular level of detail. A vulnerable adult is screened in when at least one item (i.e., Self-Neglect: Nutrition, clothing, or living environment or Physical Abuse: Physical force) is selected as present.

Overall percent agreement for the allegation items was at least 83% and the maximum percent agreement was 100% for all 28 items. One item (Self-Neglect: Substance misuse) had both 100% overall agreement and 100% minimum agreement. However, 21 items had a minimum percent agreement below 75%, and four of those items had vignettes with split agreement (50%; Table 2).

**TABLE 2**

**IRR RESULTS**
**SECTION 1, PART B: ALLEGATION SCREENING CRITERIA**

| ALLEGATION ITEM | OVERALL % AGREEMENT | MINIMUM % AGREEMENT | MAXIMUM % AGREEMENT |
|---|---|---|---|
| **Self-Neglect** | | | |
| Nutrition, clothing, or living environment | 89% | 54% | 100% |
| Personal hygiene | 96% | 67% | 100% |
| Medical or mental health care | 91% | 50% | 100% |
| Substance misuse | 100% | 100% | 100% |
| Dangerous behaviors | 95% | 75% | 100% |
| Inability/failure to manage income, assets, or property | 95% | 67% | 100% |
| **Neglect by a Caregiver** | | | |
| Nutrition, clothing, or living environment | 90% | 50% | 100% |
| Personal care or hygiene | 94% | 58% | 100% |
| Medical or mental health care | 91% | 56% | 100% |
| Supervision for safety | 83% | 50% | 100% |
| **Emotional Abuse** | | | |
| Harassment, threats, intimidation, or disrespect | 92% | 59% | 100% |
| Unreasonable confinement—non-physical | 93% | 67% | 100% |
| Nonconsensual exposure to sexual acts or materials | 97% | 70% | 100% |
| **Physical Abuse** | | | |
| Physical injury, pain, or harm | 97% | 70% | 100% |
| Physical force | 96% | 56% | 100% |
| Unreasonable confinement—physical | 92% | 78% | 100% |
| **Sexual Abuse** | | | |
| Unwanted sexual contact | 97% | 70% | 100% |
| Sexual utilization for gratification of others | 96% | 52% | 100% |
| Forcing, compelling, or enticing adult to perform sexual services | 95% | 52% | 100% |
| **Financial Exploitation** | | | |
| Enticing, compelling, or coercing adult to perform services | 98% | 87% | 100% |
| Suspected loss of assets, property, or resources due to theft, fraud, coercion, undue influence, or scam | 97% | 83% | 100% |
| Another person unlawfully withholding assets | 94% | 50% | 100% |

Evident Change recommends minor language changes to certain items that tested below the 75% testing threshold. These language changes are intended to add clarity in areas that may have resulted in lower consistency during testing. Evident Change recommends focusing on areas that tested lower during training to support staff in their understanding and use of the intake assessment.

## LOCAL PRIORITIZATION GUIDELINES

The recommended intake screening decision can be overridden to screen out with a local prioritization guideline. For this section, the number of times each guideline was selected is reported rather than the consistency of items among raters.

Of the 381 responses analyzed, workers applied at least one local prioritization guideline in 28 instances. The item "Self-neglect can be resolved and the adult's health and safety addressed through case management" was applied most often. "Something else not listed above" was selected 13 times.

**TABLE 3**

**IRR RESULTS**
**SECTION 1, PART C: LOCAL PRIORITIZATION GUIDELINE REASON**

| ITEM | N |
|---|---|
| Self-neglect can be resolved and the adult's health and safety addressed through case management. | 12 |
| Abuse, neglect, or financial exploitation has stopped; risk of maltreatment reoccurrence is reduced and the adult's needs, including health and safety, are met through services or supports. | 4 |
| Adult is deceased at time of report. | 1 |
| Adult is no longer in Minnesota. | 1 |
| Adult is incarcerated; APS is unable to engage in assessment or service intervention at time of report. | 1 |
| Alleged maltreatment based on informed choice. | 2 |
| APS lacks resources for assessment. | 1 |
| Something else not listed above. | 13 |

Evident Change recommends finalizing the SDM intake assessment with the local agency prioritization reasons.[1] Evident Change recommends providing ample training support to staff regarding the use of agency prioritization (e.g., how this section is used, how it connects to policy, and ensuring it is applied as intended).

[1] Evident Change had no recommendations for changes to the agency prioritization reasons based on the IRR results. Upon presenting findings to the SDM advisory team (APS Partnership Group), county representatives raised separate concerns that led to policy-based changes.

## RESPONSE PRIORITY

The response priority portion of the intake assessment guides in-person response times for vulnerable adults. Emergency protective services (EPS) criteria were not tested. Four criteria items determine whether a report warrants an APS response within 24 hours. If no 24-hour response items apply, the recommended response time is within 72 hours.

Overall percent agreement for all 24-hour response times was 82% or higher and was 72% for the 72-hour response time item. Minimum agreement was below 75% for three of the 24-hour items and for the 72-hour item. Maximum agreement was 100% for all items, meaning that all participants agreed on the item definition for at least one vignette (Table 4).

**TABLE 4**

**IRR RESULTS**
**SECTION 4, RESPONSE PRIORITY ITEMS (N 381)**

| ITEM | OVERALL % AGREEMENT | MINIMUM % AGREEMENT | MAXIMUM % AGREEMENT |
|---|---|---|---|
| **Priority Response Within 24 Hours** | | | |
| Adult is in danger of immediate harm, physical or sexual assault, injury, loss of health, or death due to abuse, neglect, or self-neglect. | 82% | 50% | 100% |
| Adult has been harmed, and person alleged responsible has access to the adult or other adults vulnerable to maltreatment. | 90% | 52% | 100% |
| The adult's fear of the person alleged responsible interferes with their ability to meet their ADLs or IADLs. | 93% | 78% | 100% |
| The adult's resources are being mismanaged or misappropriated AND there is an immediate concern for preserving assets. | 90% | 58% | 100% |
| **Response Within 72 Hours** | | | |
| No 24-hour response items apply. | 72% | 56% | 100% |

Evident Change recommends making minor language changes to certain items that tested below 75%. These changes are intended to add clarity in areas that may have resulted in lower consistency during testing. Evident Change recommends that training be used to focus on areas that tested lower to support staff in their understanding and use of the intake assessment.

# APPENDIX A: IRR RESULTS BY VIGNETTE

Table A1 shows the percent agreement for vulnerable adult status questions across the 15 vignettes for which there are responses. For example, of the 25 participants who completed Vignette 2, 100% agreed on the response to "Adult receives personal care assistance (PCA) paid for under the medical assistance program." If no participants answered a question for a vignette, a dash is shown. Shaded cells indicate vignettes and items where agreement among participants fell below 75%. Note that due to the logic of the items in this section, some had a small number of responses (e.g., N = 2). Results should be viewed in the context of their sample size.

**TABLE A1**
**IRR RESULTS BY VIGNETTE**
**VULNERABLE ADULT STATUS ITEMS**

| ITEM[2] | VIGNETTE NUMBER[3] | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| Adult receives personal care assistance (PCA) paid for under the medical assistance program. | N = 25<br>100% | N = 24<br>100% | N = 24<br>83% | N = 24<br>100% | N = 24<br>100% | N = 24<br>96% | N = 24<br>100% | N = 27<br>74% | N = 27<br>93% | N = 27<br>96% | N = 26<br>100% | N = 50<br>98% | N = 26<br>100% | N = 26<br>100% | N = 26<br>100% |
| Adult is participating in a licensed service. | N = 25<br>100% | N = 24<br>96% | N = 24<br>100% | N = 24<br>100% | N = 24<br>71% | N = 24<br>100% | N = 24<br>54% | N = 27<br>93% | N = 27<br>96% | N = 27<br>100% | N = 26<br>100% | N = 50<br>98% | N = 26<br>100% | N = 26<br>100% | N = 25<br>100% |
| Adult is believed to have diagnosis or condition impairing physical, cognitive, or emotional functions. | N = 25<br>76% | N = 23<br>96% | – | N = 24<br>96% | – | – | – | N = 2<br>100% | N = 25<br>76% | N = 26<br>81% | N = 26<br>100% | N = 49<br>53% | N = 26<br>92% | N = 26<br>81% | N = 25<br>100% |
| Adult is believed to have impaired ability to complete their own ADLs or IADLs without assistance. | N = 25<br>96% | N = 23<br>61% | – | N = 24<br>96% | – | – | – | N = 2<br>100% | N = 25<br>96% | N = 26<br>88% | N = 26<br>85% | N = 49<br>57% | N = 26<br>85% | N = 26<br>100% | N = 25<br>96% |

[2] Items presented here were determined by the previous answers in this section. Not all participants responded to each item.

[3] Note that 0 participants completed the vulnerable adult status section for vignette 1 due to the design of the IRR study.

| TABLE A1<br>IRR RESULTS BY VIGNETTE<br>VULNERABLE ADULT STATUS ITEMS | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ITEM[2] | VIGNETTE NUMBER[3] | | | | | | | | | | | | | | |
| | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| Adult is believed to have an impaired ability to protect themself from maltreatment. | N = 18<br>100% | N = 9<br>100% | – | N = 23<br>100% | – | – | – | N = 2<br>50% | N = 19<br>58% | N = 19<br>95% | N = 22<br>86% | N = 17<br>59% | N = 20<br>100% | N = 21<br>95% | N = 24<br>96% |
| Unable to determine vulnerability status AND there is still reason to believe the adult is eligible for screening. | N = 7<br>86% | N = 14<br>86% | – | N = 1<br>100% | – | – | – | N = 1<br>100% | N = 14<br>71% | N = 8<br>62% | N = 7<br>71% | N = 42<br>71% | N = 6<br>83% | N = 6<br>50% | N = 2<br>100% |

Table A2 shows the percent agreement for each allegation screening item by vignette. For example, after reviewing Vignette 3, 96% of participants agreed on the scoring for "Self-Neglect: Nutrition, clothing, or living environment." Shaded cells indicate where percent agreement fell below 75% for each allegation item across the 16 vignettes.

| TABLE A2<br>IRR RESULTS BY VIGNETTE<br>MALTREATMENT ALLEGATIONS | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALLEGATION ITEMS | VIGNETTE NUMBER[4] | | | | | | | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 14 | 15 | 16 |
| | N 53 | N 27 | N 27 | N 27 | N 27 | N 27 | N 27 | N 26 | N 24 | N 24 | N 24 | N 23 | N 24 | N 24 | N 24 |
| **Self-Neglect** | | | | | | | | | | | | | | | |
| Nutrition, clothing, or living environment | 96% | 100% | 96% | 96% | 93% | 100% | 100% | 96% | 62% | 100% | 62% | 65% | 100% | 100% | 54% |
| Personal hygiene | 98% | 100% | 96% | 96% | 96% | 100% | 100% | 100% | 83% | 92% | 100% | 100% | 100% | 100% | 67% |

[4] The allegation and response priority sections were not tested against Vignette 13.

| TABLE A2<br>IRR RESULTS BY VIGNETTE<br>MALTREATMENT ALLEGATIONS | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ALLEGATION ITEMS** | **VIGNETTE NUMBER[4]** | | | | | | | | | | | | | | |
| | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **14** | **15** | **16** |
| | N 53 | N 27 | N 27 | N 27 | N 27 | N 27 | N 27 | N 26 | N 24 | N 24 | N 24 | N 23 | N 24 | N 24 | N 24 |
| Medical or mental health care | 96% | 100% | 96% | 93% | 52% | 100% | 100% | 96% | 83% | 100% | 100% | 96% | 100% | 100% | 50% |
| Substance misuse | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Dangerous behaviors | 100% | 100% | 96% | 100% | 89% | 100% | 100% | 92% | 88% | 75% | 100% | 96% | 100% | 100% | 88% |
| Inability/failure to manage income, assets, or property | 91% | 100% | 100% | 100% | 96% | 100% | 100% | 100% | 67% | 100% | 92% | 100% | 75% | 100% | 100% |
| **Neglect by a Caregiver** | | | | | | | | | | | | | | | |
| Nutrition, clothing, or living environment | 92% | 100% | 96% | 93% | 100% | 100% | 100% | 77% | 83% | 100% | 58% | 100% | 100% | 100% | 50% |
| Personal care or hygiene | 94% | 96% | 96% | 100% | 100% | 96% | 100% | 100% | 75% | 96% | 96% | 100% | 100% | 100% | 58% |
| Medical or mental health care | 91% | 93% | 89% | 56% | 100% | 100% | 96% | 96% | 79% | 100% | 96% | 100% | 100% | 100% | 71% |
| Supervision for safety | 89% | 100% | 74% | 59% | 100% | 100% | 85% | 77% | 75% | 79% | 54% | 100% | 100% | 100% | 50% |
| **Emotional Abuse** | | | | | | | | | | | | | | | |
| Harassment, threats, intimidation, or disrespect | 98% | 100% | 89% | 96% | 100% | 89% | 59% | 81% | 96% | 100% | 88% | 100% | 100% | 83% | 100% |
| Unreasonable confinement, forced separation, involuntary seclusion, or deprivation—non-physical | 96% | 74% | 100% | 67% | 100% | 96% | 100% | 85% | 100% | 100% | 79% | 100% | 100% | 96% | 100% |
| Nonconsensual exposure to sexual acts or materials | 100% | 100% | 70% | 100% | 100% | 100% | 89% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 100% |
| **Physical Abuse** | | | | | | | | | | | | | | | |
| Physical injury, pain, or harm | 100% | 96% | 70% | 100% | 100% | 100% | 100% | 85% | 96% | 100% | 100% | 100% | 100% | 100% | 100% |
| Physical force | 100% | 100% | 56% | 100% | 100% | 100% | 100% | 81% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

| TABLE A2<br>IRR RESULTS BY VIGNETTE<br>MALTREATMENT ALLEGATIONS | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALLEGATION ITEMS | VIGNETTE NUMBER[4] | | | | | | | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 14 | 15 | 16 |
| | N 53 | N 27 | N 27 | N 27 | N 27 | N 27 | N 27 | N 26 | N 24 | N 24 | N 24 | N 23 | N 24 | N 24 | N 24 |
| Unreasonable confinement, forced separation, involuntary seclusion, or deprivation—physical | 89% | 81% | 78% | 81% | 100% | 89% | 100% | 81% | 100% | 100% | 96% | 100% | 100% | 100% | 96% |
| **Sexual Abuse** | | | | | | | | | | | | | | | |
| Unwanted sexual contact | 100% | 100% | 96% | 100% | 100% | 100% | 70% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 100% |
| Sexual utilization for gratification of others | 100% | 100% | 96% | 100% | 100% | 100% | 52% | 100% | 100% | 100% | 100% | 100% | 100% | 96% | 100% |
| Forcing, compelling, or enticing the adult to perform sexual services | 100% | 100% | 52% | 100% | 100% | 100% | 81% | 100% | 100% | 100% | 100% | 100% | 100% | 96% | 100% |
| **Financial Exploitation** | | | | | | | | | | | | | | | |
| Enticing, compelling, or coercing the adult vulnerable to maltreatment to perform services for the profit or benefit of another | 87% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 96% | 100% | 100% |
| Suspected loss of assets, property, or resources due to theft, fraud, coercion, undue influence, or scam | 92% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 100% | 83% | 100% | 100% |
| Another person is unlawfully withholding assets, property, or resources | 83% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 92% | 100% | 50% | 100% | 100% |

Table A3 contains the percent agreement among raters for the response priority items by vignette. Note that response priority agreements are not shown for vignettes 10 and 13. For vignette 10, more than 50% of participants indicated the report should be screened out and thus were not asked to complete the response priority section of the tool. Definitions were not tested against vignette 13.

**TABLE A3**
**RESPONSE PRIORITY ITEMS**

| RESPONSE PRIORITY ITEM | VIGNETTE | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 11 | 12 | 14 | 15 | 16 |
| | N = 53 | N 27 | N = 27 | N = 27 | N = 27 | N = 27 | N = 27 | N = 23 | N = 24 | N = 24 | N = 23 | N = 24 | N = 24 | N = 24 |
| Adult is in danger of immediate harm, physical or sexual assault, injury, loss of health, or death due to abuse, neglect, or self-neglect. | 94% | 96% | 81% | 89% | 59% | 100% | 78% | 65% | 71% | 50% | 100% | 100% | 79% | 75% |
| Adult has been harmed, and person alleged responsible has access to the adult or other adults vulnerable to maltreatment. | 98% | 89% | 74% | 96% | 100% | 96% | 74% | 52% | 100% | 96% | 100% | 96% | 92% | 88% |
| The adult's fear of the person alleged responsible interferes with their ability to meet their ADLs or IADLs. | 87% | 85% | 78% | 96% | 100% | 96% | 96% | 87% | 100% | 96% | 100% | 100% | 100% | 92% |
| The adult's resources are being mismanaged or misappropriated AND there is an immediate concern for preserving assets. | 60% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 88% | 91% | 58% | 96% | 100% |
| | | | | | | | | | | | | | | |
| No 24-hour response items apply. | 64% | 74% | 100% | 78% | 56% | 96% | 63% | 61% | 71% | 58% | 91% | 58% | 67% | 83% |

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# INTER-RATER RELIABILITY TESTING INSTRUCTIONS:

## SDM® Intake 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 Intake Assessment?**

We will ask participants to read a series of vignettes describing situations that require an intake assessment. Participants will complete an SDM intake 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 intake 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 2: WEB REPORT

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Jacob Anderson
- Age: 82
- Race: American Indian
- Gender: Male
- Physical location: 111 Lakeview Ave. Windom, MN 56101, Cottonwood Co.

**Person Alleged Responsible:** Unknown, Unknown
- Age: Estimated 75
- Race: American Indian
- Gender: Female
- Physical location: Unknown

**Reporter:** Unknown, Unknown
- Address: Unknown

### ADULT MALTREATMENT TAB

**Source:** Friend/acquaintance/neighbor
**Reporter**: Unknown, Unknown
**Incident**
- Estimated date/time: 7/19/2023, 12:30 p.m.
- Location of incident: 111 Lakeview Ave. Windom, MN (VA's home)
- County of incident: Cottonwood

**Reporter Requests Initial Disposition**: No

### VICTIM INFORMATION TAB

**Alleged Victim**: Anderson, Jacob
**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:** Frailty of aging, physical impairment
**Needs Assistance**: Don't know
**Receives Services**: Unknown

**Diagnosis if Known**: N/A

**DESCRIPTION OF INCIDENT TAB**

Jacob is my neighbor. Age 82. His family is bad to him—they are messing with his head. I feel bad for him. He's so frail he can barely walk and can't just leave the house whenever he wants any longer. He uses a wheelchair all the time now. We barely see him anymore but when we do, he acts very afraid, flinches when we say hello, and won't talk to us. He used to be happy and talk to us every day. His sister tells him he's a worthless piece of garbage and that she wishes he would die. She tells him that he's going to die any day. She's always talking about him dying or moving him to a nursing home. She screams terrible things at him all day. Something is wrong with her. She never leaves him alone. I called the cops, and they didn't do anything. I don't know what else she does to him in there. Sometimes I hear him moan, or say PLEASE until she yells, and he gets quiet. Now that he's in the chair all the time he can't get away, and he needs help doing things. I don't know what's going on in there. Please help Jacob.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: Unknown, Unknown
**Alleged Perpetrator Description**: Female approximately 5' 5" grey hair and wears glasses
**Nature of Allegation**: Emotional or Mental Abuse – Oral communication

**IMPACT/EFFECT ON VA TAB**

**Worsening physical or mental health:** Unknown

**ROLES TAB**

- Unknown, Unknown: Alleged perpetrator
- Unknown, Unknown: Sister
- Unknown, Unknown: Reporter
- Anderson, Jacob: Alleged victim

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: None
**Notification Made by Reporter**: Law Enforcement because crime was alleged

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 3

### 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 themself 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 4

### 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 5

### 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 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 themself. 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 on 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

STOP. COMPLETE THE INTAKE ASSESSMENT.

## VIGNETTE 6

### 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 7

### 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 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 8

### 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 themself 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 9

### 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 themself. 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

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 10

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Cooper Anderson
- Age: 20
- Race: Caucasian
- Gender: Male
- Physical location: 8392 Jasmine St., Virginia, MN 55792

**Person Alleged Responsible:** Samantha Anderson
- Age: estimated to be in mid to late 40s
- Race: Caucasian
- Gender: Female
- Physical location: 8392 Jasmine St., Virginia, MN 55792

**Reporter**: Amy James
- Address: 1201 S. 13th Ave. W, Virginia, MN 55792

### ADULT MALTREATMENT TAB

**Source**: School SW
**Reporter**: James, Amy
**Incident**:
- Estimated date/time: 7/7/2023
- Location of incident: 8392 Jasmine St., Virginia, MN 55792
- County of incident: St. Louis

**Reporter Requests Initial Disposition**: Yes

### VICTIM INFORMATION TAB

**Alleged Victim**: Anderson, Cooper
**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:** Physical
**Needs Assistance**: Toileting, supervision
**Receives Services**: Informal/Family Caregiver

**Diagnosis if Known**:

**DESCRIPTION OF INCIDENT TAB**

The VA, who is a student at the school, came to school this morning with a cut and bruised lip. The VA told the reporter that they were injured after falling off the toilet.

The VA lives with the AP, father, and teenage brother, who all provide care. The VA needs assistance going to the bathroom. The reporter asked the VA why nobody helped them use the bathroom, and the VA replied that the AP said they would help the VA in one minute, but the VA decided to try to use the bathroom unassisted. The VA told the reporter that they are not hurt and just want to be more independent; they said the AP rushed to the bathroom as soon as the AP heard the VA fall. The VA told the reporter the AP made the VA promise to always wait for the AP to help from now on.

The reporter is concerned about neglect because the VA is dependent on others for personal care and assistance. The reporter believes the AP should have been there immediately to help VA use the bathroom.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: Anderson, Samantha
**Alleged Perpetrator Description:**
**Nature of Allegation:** Caregiver neglect - supervision

**ROLES TAB**

- Anderson, Cooper: Alleged victim
- Anderson, Samantha: Alleged perpetrator
- James, Amy: Reporter
- James, Amy: School social worker

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: N/A
**Notification Made by Reporter**: No

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 11

**FOUND IN THE PERSON NODES IN THE TREE**

**Adult Suspected to Be Vulnerable:** Sonia Kelly

- Age: 75
- Race: Asian
- Gender: Female
- Physical location: 98 Wheeler St. S, Saint Paul, MN 55105

**Person Alleged Responsible:** Martin Kelly

- Age: unknown
- Race: Asian
- Gender: Male
- Physical location: 98 Wheeler St. S, Saint Paul, MN 55105 (VA's home)

**Reporter**: Vivian Charles

- Address: 96 Wheeler St. S, Saint Paul, MN 55105

**ADULT MALTREATMENT TAB**

**Source**: Neighbor
**Reporter**: Charles, Vivian
**Incident**

- Estimated date/time: 7/25/2023, 11:57 a.m.
- Location of incident: 98 Wheeler St. S, Saint Paul, MN 55105 (VA's home)
- County of incident: Ramsey

**Reporter requests initial disposition**: Yes

**VICTIM INFORMATION TAB**

**Alleged Victim**: Kelly, Sonia
**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, frailty of aging (visual impairment)
**Needs Assistance**: Financial management, food, safety, supervision, toileting, unable to protect self from abuse/neglect/financial exploitation
**Receives Services**: Informal/family caregiver

**Diagnosis if Known**: Visually impaired

## DESCRIPTION OF INCIDENT TAB

The VA's former caregiver, who was their daughter, recently passed away. The VA's new caregiver is their son. The reporter stated that the AP frequently leaves the VA at home by themself, with no suitable care arrangement. The VA is visually impaired, which impedes their ability to move around by themself. The reporter is worried by the lack of supervision and adequate care that the AP is providing for the VA. The reporter is further worried that the VA may fall and hurt themself when left alone. The reporter is also worried that the AP will spend the VA's funds. The reporter shared that the daughter left the VA a large sum of money and that the AP now controls the VA's money. When the AP gets upset with the VA, the AP punishes them by refusing to give them money for groceries or anything else they would like to purchase that day.

The reporter strongly feels the AP is unable to monitor the VA's care and that when the AP doesn't allow the VA to purchase food, the VA is not eating. The VA has now gone a few days without eating due to the AP withholding money, and the VA has lost weight as a result.

## ALLEGATIONS TAB

**Alleged perpetrator name**: Kelly, Martin
**Alleged perpetrator description**:
**Nature of Allegation**

- Caregiver neglect – food
- Caregiver neglect – lack of supervision
- 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

Weight loss, malnutrition or dehydration; AP's behavior creates a health or safety risk for VA

## ROLES TAB

- Kelly, Sonia: Alleged victim
- Kelly, Martin: Alleged perpetrator
- Kelly, Martin: Son
- Kelly, Martin: Caregiver
- Charles, Vivian: Reporter
- Charles, Vivian: Neighbor

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: N/A
**Notification Made by Reporter**: None

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 12

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Ada Thomas
- Age: 81
- Race: Caucasian
- Gender: Female
- Physical location: 820 Santa Vera Dr., Chanhassen, MN 55317

**Reporter**: Alex Thomas
- Address: 2181 Lake Lucy Rd., Chanhassen, MN 55317

### ADULT MALTREATMENT TAB

**Source**: Family
**Reporter**: Thomas, Alex
**Incident**
- Estimated date/time: 7/1/2023, 7:15 p.m.
- Location of incident: 820 Santa Vera Dr., Chanhassen, MN 55317
- County of incident: Carver

**Reporter requests initial disposition**: Yes

### VICTIM INFORMATION TAB

**Alleged Victim**: Thomas, Ada
**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
**Needs Assistance**: Housing assistance
**Receives Services**: Unknown
**Diagnosis if Known**: Potentially dementia

**DESCRIPTION OF INCIDENT TAB**

The reporter called to report their worries over the VA's ability to care for themself. The reporter stated that over the past few months, they have noticed the VA becoming forgetful and getting easily confused over things. The reporter mentioned an incident where the VA called to ask the reporter for details of VA's address as the VA could not remember where they lived. The reporter shared that the VA lives alone in a private apartment. The reporter said they will check in on the VA as often as possible, but the reporter is worried that the VA may need more help than they can give. The reporter decided to seek assistance as the VA disclosed that they are facing eviction in 30 days for not paying their rent for the past three months. The VA was unsure why they had to pay for the rent when they did not have to prior to this. The reporter was concerned that they VA could not remember about paying rent when they have paid faithfully every month.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: Ada Thomas, self
**Nature of Allegation**:

- Self-neglect – shelter
- Self-neglect – services essential to welfare or safety of the person

**IMPACT/EFFECT ON VA TAB**

Worsening mental health of the VA resulting in several episodes of forgetfulness and inability of VA to care for self; VA facing housing eviction within next 30 days (eviction notice served on 7/1/2023).

**ROLES TAB**

- Thomas, Ada: Alleged perpetrator
- Thomas, Ada: Alleged victim
- Thomas, Alex: Reporter
- Thomas, Alex: Son

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: None reported
**Notification Made by Reporter**: None

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 13

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Jonathan Norman
- Age: 55
- Race: Black
- Gender: Male
- Physical location: 5300 France Ave. N, Brooklyn Center, MN 55429

**Reporter**: Jackson Lee
- Address: 6113 Quail Ave. N, Brooklyn Center, MN 55429

### ADULT MALTREATMENT TAB

**Source**: Friend
**Reporter**: Lee, Jackson
**Incident**
- Estimated date/time: 8/1/2023, 9:50 a.m.
- Location of incident: 5300 France Ave. N, Brooklyn Center, MN 55429 (VA's home)
- County of incident: Hennepin

**Reporter Requests Initial Disposition**: No

### VICTIM INFORMATION TAB

**Alleged Victim**: Norman, Jonathan
**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:** Frailty of aging, physical
**Needs Assistance**: Safety, unable to protect self from abuse/neglect/financial exploitation
**Receives Services**: Informal caregiver
**Diagnosis if Known**: Unknown

### DESCRIPTION OF INCIDENT TAB

The reporter stated that the VA can hardly walk and complains of back pain. The VA used to drive a cement truck, which may have contributed to their pain. The VA is "mad at [their] whole family and the

world." They live in their parents' mother-in-law unit and watch television all day. The reporter stated that they have been trying to get some help for the VA, but the VA refuses the reporter's help/assistance. The reporter stated that while it is hard for the VA to get out of bed, the VA can do so to get food and use the bathroom independently. The VA allows the reporter to clean the VA's room and change their bedsheets. The reporter stated that someone needs to visit and talk to the VA.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: Norman, Jonathan
**Nature of Allegation:** Self-neglect – services essential to the necessary welfare or safety of the person

**IMPACT/EFFECT ON VA TAB**

VA's behavior creates a health or safety risk for VA – VA has difficulty walking and experiences chronic pain but refuses to seek in-home assistance/utilize community resources and/or medical care.

**ROLES TAB**

- Norman, Jonathan: Alleged victim
- Norman, Jonathan: Alleged perpetrator
- Lee, Jackson: Reporter
- Lee, Jackson: Friend

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: N/A
**Notification Made by Reporter**: None

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 14

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Leonard Williams
- Age: 75
- Race: African American
- Gender: Male
- Physical location: 507 23rd St. SW, Rochester, MN 55902

**Person Alleged Responsible:** Ian Williams
- Age: 41
- Race: African American
- Gender: Male
- Physical location: 507 23rd St. SW, Rochester, MN 55902

**Person Alleged Responsible:** Jessica Williams
- Age: 39
- Race: African American
- Gender: Female
- Physical location: 507 23rd St. SW, Rochester, MN 55902

**Reporter**: Shirley Williams
- Address: 150 19th St. NW, Cedar Rapids, IA 52405

### ADULT MALTREATMENT TAB

**Source**: Family
**Reporter**: Williams, Shirley
**Incident**
- Estimated date/time: 8/5/2023, 1:00 p.m.
- Location of incident: 507 23rd St. SW, Rochester, MN 55902
- County of incident: Olmsted

**Reporter Requests Initial Disposition**: No

**VICTIM INFORMATION TAB**

**Alleged Victim**: Williams, Leonard
**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:** unknown
**Needs Assistance**: Impaired memory, impaired reasoning or judgment
**Receives Services**: Informal or family caregiver
**Diagnosis if Known**: N/A

**DESCRIPTION OF INCIDENT TAB**

The reporter stated the VA lives in the residence of two APs.

The APs help with the VA's daily care needs. Last week, the APs took the VA to the bank. The VA told the reporter that they have never gotten any money while living with the APs, who always say the VA does not have any to use. The reporter stated that they looked at the VA's previous bank statements and noticed that each time a withdrawal was made, it was always for more than the amount the APs were charging VA for rent and food.

The reporter lives away from the VA and is concerned about the VA's failing memory and the APs' behavior. The reporter stated that the VA needs to be in an environment where they will be safe, but the APs refused the suggestions offered. Due to the extra unauthorized withdrawals from the VA's bank account, the VA also does not have enough money to pay for a new caregiver. The reporter is worried that if the APs withdraw more money from the VA's account again this week, the VA may run out of money and no longer be able to afford necessities.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: Williams, Ian and Williams, Jessica
**Nature of Allegation**: 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**

Theft, loss, transfer, unauthorized expenditures, fraud, or the withholding of money or property of unknown dollar amounts; monetary assets; reporter is worried that if the APs withdraw more money from the VA's account again this week, the VA may run out of money and no longer be able to afford necessities.

**ROLES TAB**

- Williams, Ian: Son
- Williams, Ian: Alleged perpetrator
- Williams, Jessica: Daughter in-law
- Williams, Jessica: Alleged perpetrator
- Williams, Leonard: Alleged victim
- Williams, Shirley: Daughter
- Williams, Shirley: Reporter

**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

STOP. COMPLETE THE INTAKE ASSESSMENT.

## VIGNETTE 15

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Rebecca David
- Age: 72
- Race: Caucasian
- Gender: Female
- Physical location: 716 Alcove St., Albert Lea, MN 56007

**Person Alleged Responsible:** Malcom David
- Age: 45
- Race: Caucasian
- Gender: Male
- Physical location: 716 Alcove St., Albert Lea, MN 56007

**Reporter**: Rebecca David
- Address: 716 Alcove St., Albert Lea, MN 56007

### ADULT MALTREATMENT TAB

**Source**: Self
**Reporter**: David, Rebecca
**Incident**
- Estimated date/time: 8/4/2023, 9:30 a.m.
- Location of incident: 716 Alcove St., Albert Lea, MN 56007
- County of incident: Freeborn

**Reporter Requests Initial Disposition**: No

### VICTIM INFORMATION TAB

**Alleged Victim**: David, Rebecca
**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:** Frailty of aging
**Needs Assistance**: Clothing, food, health care, hygiene, safety, supervision, toileting
**Receives Services**: Informal or family caregiver

**Diagnosis if Known**: Unknown

**DESCRIPTION OF INCIDENT TAB**

The VA reported that their caregiver, who is the VA's son, is making the VA uncomfortable, and the VA thinks that the AP might be abusing the VA. When questioned further, the VA said the AP helps them with daily needs (e.g., bathing, preparing food, some housekeeping). The VA further shared that when the AP helps the VA with bathing, the AP spends an inappropriately long time cleaning VA's private areas, which makes the VA feel uncomfortable. The AP also watches pornographic videos on the VA's laptop, in the VA's presence. The VA has told the AP to stop and requested that the AP either watch it in another room or assist to push the VA to another room. The AP has dismissed the VA's requests and told the VA to "stop being such a pain and live with it." The VA shared that the AP is going to Minneapolis tonight for at least the next week. The VA's neighbor will be assisting with their care while the AP is away. The VA hopes that someone can tell the AP not to come back to the VA's house and help the VA find another caregiver.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: David, Malcom
**Nature of Allegation**: Sexual abuse – unwanted sexual contact

**IMPACT/EFFECT ON VA TAB**

Physical, emotional, mental, or sexual injury

**ROLES TAB**

- David, Malcom: Son
- David, Malcom: Alleged perpetrator
- David, Rebecca: Alleged victim

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: Other: VA lives with abusive family member
**Notification Made by Reporter**: None

**STOP. COMPLETE THE INTAKE ASSESSMENT.**

## VIGNETTE 16

### FOUND IN THE PERSON NODES IN THE TREE

**Adult Suspected to Be Vulnerable:** Brianna King
- Age: 64
- Race: Caucasian
- Gender: Female
- Physical location: 213 Capital Dr., Mankato, MN 56001

**Person Alleged Responsible:** Martin King
- Age: 40
- Race: Caucasian
- Gender: Male
- Physical location: 213 Capital Dr., Mankato, MN 56001

**Person Alleged Responsible:** Cherilyn May
- Age: 36
- Race: Caucasian
- Gender: Female
- Physical location: 213 Capital Dr., Mankato, MN 56001

**Reporter**: Michael Rodriguez
- Address: 628 E. Rock St., Mankato, MN 56001

### ADULT MALTREATMENT TAB

**Source**: Law enforcement
**Reporter**: Rodriguez, Michael
**Incident**
- Estimated date/time: 8/8/2023, 2:45 p.m.
- Location of incident: 213 Capital Dr., Mankato, MN 56001
- County of incident: Blue Earth

**Reporter Requests Initial Disposition**: No

**VICTIM INFORMATION TAB**

**Alleged Victim**: King, Brianna
**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:** Physical, impaired memory
**Needs Assistance**: Clothing, health care, hygiene, safety, supervision, toileting, unable to protect self from abuse/neglect/financial exploitation
**Receives Services**: Informal or family caregiver
**Diagnosis if Known**: Alzheimer's

**DESCRIPTION OF INCIDENT TAB**

The reporter stated that they conducted a welfare check on the VA as a neighbor heard the VA screaming loudly for approximately 10 minutes. The neighbor reported to law enforcement that the VA was diagnosed with Alzheimer's, has poor vision, and is unable to ambulate independently. The VA's caregivers are the VA's brother and the brother's live-in girlfriend. The APs were not present at the time of the home visit. The reporter found the VA in a soiled t-shirt with bedsores all over their body. The VA's bed had no bedsheets and was covered with soiled white pads. The VA urinated on themself in front of the reporter. The reporter saw a small plastic bowl that contained dirty standing water, which the VA said they used to bathe with. The VA refused transport to the hospital and refused medical attention.

**ALLEGATIONS TAB**

**Alleged Perpetrator Name**: King, Martin and May, Cherilyn
**Nature of Allegation**

- Caregiver neglect – clothing
- Caregiver neglect – supervision
- Caregiver neglect – health care

**IMPACT/EFFECT ON VA TAB**

Hospitalization or treatment required; worsening physical or mental health; lack of necessary health care, services, or supervision; caregiver's behavior creates a health or safety risk for VA

**ROLES TAB**

- Rodriguez, Michael: Reporter
- Rodriguez, Michael: Law enforcement officer
- King, Brianna: Alleged victim
- King, Martin: Alleged perpetrator
- King, Martin: Son
- May, Cherilyn: Alleged perpetrator

**SAFETY TAB**

**Has Action Been Taken to Protect the Vulnerable Adult From Further Harm:** No
**Environmental Safety**: Other – VA lives with unhygienic conditions leading to injury
**Notification Made by Reporter**: N/A

**STOP. COMPLETE THE INTAKE ASSESSMENT.**