Electronically Delivered

July 23, 2025

Licensee
Broadwell Plymouth Senior Living
3025 North Harbor Lane
Plymouth, MN 55447

RE: Project Number(s) SL37869016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

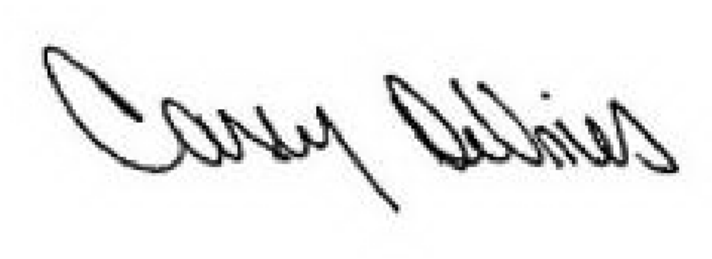
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-800-337-9238

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37869016-0 On May 19, 2025, through May 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 100 residents; 48 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to	0 430		

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0 430	Continued From page 1 prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Checklist Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2	0 430		

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0 430	Continued From page 2 R2 was admitted to the licensee on December 17, 2021. R2's Service Agreement dated May 6, 2025, indicated R2 received services for bathing, behavior management, dressing, grooming, falls, diabetes, and medication management. R3 R3 was admitted to the licensee on April 3, 2024. R3's Service Agreement dated April 25, 2025, indicated R3 received services for bathing, dressing, compression socks, grooming, laundry, and medication management. R2 and R3's records lacked evidence the licensee's UDALSA had been provided to the resident or resident representative, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and - an oral explanation of the services offered under the contract. On May 19, 2025, at 11:18 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a blood glucose check for R2. On May 21, 2025, at 11:49 a.m., director of clinical operations (DCO)-E stated they did not have documentation the UDALSA was provided to R2 and R3; they stated they were in the process of updating and completing contracts,	0 430		

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0 430	Continued From page 3 documentation, and providing the UDALSA to residents. DCO-E stated the previous licensed assisted living director (LALD) was supposed to complete the tasks but did not do so. DCO-E stated it was a problem they had across the board with many of their residents and they were currently working on correcting the problem. DCO-E stated they had no way of knowing if the previous management group had distributed the UDALSA to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to two of two residents (R2, R3).	0 450		

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0 450	Continued From page 4 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on December 17, 2021. R2's Service Agreement dated May 6, 2025, indicated R2 received services for bathing, behavior management, dressing, grooming, falls, diabetes, and medication management. R3 R3 was admitted to the licensee on April 3, 2024. R3's Service Agreement dated April 25, 2025, indicated R3 received services for bathing, dressing, compression socks, grooming, laundry, and medication management. R2 and R3's records lacked evidence the assisted living BOR were distributed to the resident or resident's representative. On May 19, 2025, at 11:18 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a blood glucose check for R2. On May 21, 2025, at 11:49 a.m., director of clinical operations (DCO)-E stated they did not have documentation the BOR were provided to	0 450		

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0 450	Continued From page 5 R2 and R3; they stated they were in the process of updating and completing contracts, documentation, and providing the BOR to residents. DCO-E stated the previous licensed assisted living director (LALD) was supposed to complete the tasks but did not do so. DCO-E stated it was a problem they had across the board with many of their residents and they were currently working on correcting the problem. DCO-E stated they had no way of knowing if the previous management group had distributed the BOR to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that	0 510		

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0 510	Continued From page 6 complied with accepted health care, medical and nursing standards for infection control related to hand hygiene. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 20, 2025, at 10:12 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-H enter R5's room; neither performed hand hygiene. With soiled hands, the surveyor observed ULP-C and ULP-H applied gloves. ULP-C and ULP-H raised R5's bed and pulled it out away from the wall. With their gloves still on, ULP-C left the room to find a nurse. ULP-C returned with registered nurse (RN)-J to decide if they should get R5 out of bed. RN-J stated R5 was receiving hospice care and was nearing end-of-life. They decided not to get R5 out of bed. RN-J did not perform hand hygiene. With soiled hands, the surveyor observed RN-J apply gloves. ULP-C and ULP-H used a washable bed pad to reposition R5. With soiled gloves, ULP-H washed and dried R5's face. ULP-H removed their gloves and put them in a bag; ULP-H did not perform hand hygiene. With soiled hands, ULP-H applied lip balm to R5's lips. ULP-C removed their gloves, picked up their iPad tablet, opened R5's room door by touching the doorknob and exited the	0 510		

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0 510	Continued From page 7 room. ULP-C quietly stated, "I will wash my hands," and exited R5's room without performing hand hygiene. With soiled hands, ULP-H lowered R5's bed to the low position and put a pillow between R5's legs. The surveyor observed a half full bottle of hand sanitizer in R5's room near the kitchen sink at 10:32 a.m. With soiled hands, ULP-H exited R5's room touching the doorknob. ULP-H walked to the kitchen and washed their hands in one of the memory care (MC) kitchen sinks. On May 20, 2025, at 10:34 a.m., ULP-H stated they knew they made a mistake as they had not performed hand hygiene prior to applying and after removing gloves. ULP-H stated, "there is no hand sanitizer in the room." The surveyor explained to ULP-H they observed sanitizer in R5's room. ULP-H stated, "Oh, it was a mistake." The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on January 30, 2020, indicated The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment	0 510		

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0 510	Continued From page 8 - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal Healthcare facilities should: - Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations - Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled - Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands." The licensee's Hand Hygiene policy dated July 23, 2021, indicated: "1. When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using a restroom" The licensee's Procedure for Using Gloves policy dated July 23, 2021, indicated, " POLICY: Gloves	0 510		

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0 510	Continued From page 9 are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container." Further it indicated: "PROCEDURE: 1. Wash Hands 2. Apply gloves to both hands 3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task. 4. Place any contaminated materials in proper receptacle - such as biohazardous waste for wound care dressings. 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove. 6. Dispose of used gloves in proper receptacle - biohazardous if they have contaminated material on them. 7. Rewash hands." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 20, 2025, the surveyor toured the facility with regional environmental services director (RESD)-F. The following was observed. The doors in the memory care unit leading from the resident rooms to the common hallway were marked as fire doors and were equipped with closers. A majority of the resident room doors were propped open with chalks hindering the doors from operating properly. Multiple trash and recycling chute doors would not close and latch from the open position. Where openings are required to be protected, opening protectives shall be maintained self-closing or automatic closing by smoke detection.	0 775		

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BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 775	Continued From page 11 There was a mobility scooter that was being stored in the common hallway outside of 418. RESD-F stated that the mobility scooter is regularly stored in the common hallway. Storage is not allowed in the common hallway that can cause an exit obstruction and reduce the width of the hallway. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 12 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 20, 2025, regional environmental services director (RESD)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee's training records indicated staff received only one training in 2024 on the FSEP.	0 810		

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0 810	Continued From page 13 On May 20, 2025, regional environmental services director (RESD)-F stated they understood the requirements for staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. On May 20, 2025, regional environmental services director (RESD)-F stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has	0 900		

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0 900	Continued From page 14 been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract with the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on December 17, 2021. R2's Service Agreement dated May 6, 2025, indicated R2 received services for bathing, behavior management, dressing, grooming, falls, diabetes, and medication management.	0 900		

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0 900	Continued From page 15 R3 R3 was admitted to the licensee on April 3, 2024. R3's Service Agreement dated April 25, 2025, indicated R3 received services for bathing, dressing, compression socks, grooming, laundry, and medication management. R2 and R3's records lacked evidence the licensee executed a written contract for both residents. On May 19, 2025, at 11:18 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a blood glucose check for R2. On May 21, 2025, at 11:49 a.m., director of clinical operations (DCO)-E stated their management company, who took over the management duties of the licensee in November 2024, had not executed a contract with R2. DCO-E stated their previous LALD was supposed to execute new contracts but failed to do so. DCO-E stated R3 had the same contract issue as did many of their residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:	0 950		

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0 950	Continued From page 16 "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language, separate from the resident contract, giving residents the right to identify a designated representative for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 950		

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0 950	Continued From page 17 the residents). The findings include: R2 R2 was admitted to the licensee on December 17, 2021. R2's Service Agreement dated May 6, 2025, indicated R2 received services for bathing, behavior management, dressing, grooming, falls, diabetes, and medication management. R3 R3 was admitted to the licensee on April 3, 2024. R3's Service Agreement dated April 25, 2025, indicated R3 received services for bathing, dressing, compression socks, grooming, laundry, and medication management. On May 19, 2025, at 11:18 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a blood glucose check for R2. On May 21, 2025, at 11:49 a.m., director of clinical operations (DCO)-E stated they could not locate a completed designated representative form completed for either R2 or R3. DCO-E stated their previous licensed assisted living director (LALD) was supposed to implement a process to make sure they had been completed. DCO-E stated it was an issue being addressed across the board with their residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		

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01440	Continued From page 18	01440		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-B, ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01440		

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01440	Continued From page 19 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on January 15, 2023, to provide direct cares to residents. ULP-B's employee record lacked evidence a RN 30-day supervision was completed. ULP-C ULP-C was hired on November 7, 2024, to provide direct cares to residents. ULP-C's employee record lacked evidence a RN 30-day supervision was completed. On May 21, 2025, at 11:49 a.m., licensed assisted living director (LALD)-D and director of clinical operations (DCO)-E stated they had been working on getting through their employee records to make sure their ULPs had completed RN 30-day supervisions. They stated registered nurse (RN)-J was completing ULP-B and ULP-C's RN 30-day supervisions today during the survey. On May 21, 2025, at 12:30 p.m., DCO-E provided ULP-B and ULP-C's Notes on Supervision of Personnel form dated May 20, 2025, used for nursing observations of ULP. DCO-E stated both had just been completed by RN-J. The licensee's Supervision, Training & Competency of Delegated Nursing Services, Treatments or Therapy Tasks policy dated	01440		

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01440	Continued From page 20 November 15, 2019, indicated: "1. The Director of Health and Wellbeing RN or other delegated RN, conducts ULP training in the proper methods to perform the delegated service/task/therapies/treatments the training is documented and maintained in the team member training file. 2. Upon successful completion of training as demonstrated by written or oral test the RN performs a skills competency evaluation (supervision) of the ULPs ability to safely perform the delegated service/task/therapies/treatments including medication administration when delegated: a. Prior to the ULP providing home care services independently b. Within 30 days after the ULP begins performing delegated nursing tasks and thereafter as needed based on performance. c. When an ULP has not performed delegated tasks for one year or longer." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01540 SS=E	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two	01540		

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01540	Continued From page 21 hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two hours of required annual dementia care training was completed for two of three direct-care employees (unlicensed personnel (ULP)-B), ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on January 15, 2023, to provide direct cares to residents.	01540		

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01540	Continued From page 22 ULP-B's Relias Transcript (online training platform) indicated ULP-B last completed dementia training on April 7, 2024. ULP-B's employee record lacked evidence of two hours of annual dementia training. ULP-C ULP-C was hired on November 7, 2024, to provide direct cares to residents. ULP-C's Relias Transcript indicated ULP-C had six hours of initial dementia training. ULP-C's employee record lacked evidence of eight hours of initial dementia training being completed at the time of hire. On May 21, 2025, at 11:49 a.m., director of clinical operations (DCO)-E stated ULP-B did not have annual dementia training completed and ULP-C only had six hours of initial dementia training. DCO-E stated the previous licensed assisted living director (LALD) didn't impliment training like they were supposed to; they planned to do training on the employee's work anniversaries and were implimenting a process to get trainings up to date. The licensee's Dementia Training Requirements policy dated July 19, 2021, indicated: "Required training hours, initial and ongoing: a. Supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter. b. Direct-care employees must have completed at least eight hours of initial training within 80	01540		

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01540	Continued From page 23 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer or a supervisor meeting the requirements must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter. c. Staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the	01880		

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01880	Continued From page 24 temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for four of four residents (R2, R6, R7, R8) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's Medication Administration Record (MAR) for May 2025, indicated R2 took Toujeo (insulin glargine) Solostar pen-injector 300 units (u)/milliliter (ml), inject 65 units (u) subcutaneously (SQ) daily May 1-21, 2025. R6 R6's MAR for May 2025, indicated R6 took Lantus Solostar insulin pen 100u/ml, inject 30u SQ daily and was administered on May 1-21, 2025. R7 R7's MAR for May 2025, indicated R7 took Lantus Solostar insulin pen 100u/ml, inject 10u SQ in the morning and was administered on May 1-21, 2025. R8 R8's MAR for May 2025, indicated R8 took latanoprost solution 0.005%, instill one drop into both eyes daily at bedtime and was administered	01880		

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BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

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01880	Continued From page 25 on May 1-20, 2025. On May 19, 2025, at 11:25 a.m., the surveyor observed the facility medication refrigerator in the nursing office on the memory care (MC) unit with clinical nurse supervisor (CNS)-A. The surveyor observed the temperature of the refrigerator was 40.5 degrees Fahrenheit (F); it had a blank temperature log sitting on top of it. CNS-A stated they had another temperature log somewhere and would provide it. The surveyor observed the contents of the medication refrigerator included the following medications: -R2 Toujeo insulin glargine pen-injector 300u/ml; -R6 Lantus Solostar insulin pen 100u/ml; -R7 Lantus Solostar insulin pen 100u/ml; and -R8 latanoprost solution 0.005%. On May 20, 2025, at 9:15 a.m., the surveyor requested the medication refrigerator temperature log. CNS-A stated they would get it. On May 20, 2025, at 11:12 a.m., regional registered nurse (RN)-K stated they did not have a temperature log. RN-K stated if they were tracking temperatures, they could not find the documentation. On May 20, 2025, at 11:24 a.m., licensed practical nurse (LPN)-L stated refrigerator temperatures were not being completed. Manufacturer instructions for Lantus, last revised in 2022, indicated store unused Lantus in a refrigerator between 36-46 degrees Fahrenheit (F); discard if Lantus has been frozen. Manufacturer instructions for latanoprost, last revised in August 2011, indicated to store unopened bottles under refrigeration at 36-46	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

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01880	Continued From page 26 degrees F. The licensee's Medication Storage policy dated May 12, 2025, indicated, "b. The Waters will monitor and document the temperature of the medication refrigerator daily using the designated temperature log. The goal is to maintain a stable internal temperature between 36°F and 46°F (2°C and 8°C) to ensure the efficacy of medications, particularly vaccines and other temperature-sensitive drugs." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

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02040	Continued From page 27 This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: A record review of available documentation and interview were conducted May 20, 2025, with regional environmental services director (RESD)-F, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on May 20, 2025, RESD-F, stated an HVA had not been performed and documented on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	05/21/2025

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02110	Continued From page 28 procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents or the residents' legal and designated representatives at the time of	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	05/21/2025

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02110	Continued From page 29 move-in for two of two dementia care residents (R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2 was admitted to the licensee on December 17, 2021. R2's Service Agreement dated May 6, 2025, indicated R2 received services for bathing, behavior management, dressing, grooming, falls, diabetes, and medication management. R3 R3 was admitted to the licensee on April 3, 2024. R3's Service Agreement dated April 25, 2025, indicated R3 received services for bathing, dressing, compression socks, grooming, laundry, and medication management. R2 and R3's records lacked evidence the required dementia policies and procedures were provided to residents and the residents' legal and designated representatives at the time of move-in. On May 19, 2025, at 11:18 a.m., the surveyor observed unlicensed personnel (ULP)-B complete a blood glucose check for R2.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37869	A. BUILDING: _____ B. WING _____	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROADWELL PLYMOUTH SENIOR LIVING	3025 NORTH HARBOR LANE PLYMOUTH, MN 55447

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02110	Continued From page 30 On May 21, 2025, at 11:49 a.m., director of clinical operations (DCO)-E stated they did not have documentation the required dementia care policies were provided to R2 and R3 or their representatives; they stated they were in the process of updating and completing contracts, documentation and providing the required dementia policies and procedures to residents. DCO-E stated the previous licensed assisted living director (LALD) was supposed to complete the tasks but did not do so. DCO-E stated it was a problem they had across the board with many of their residents and they were currently working on correcting the problem. DCO-E stated they had no way of knowing if the previous management group had distributed the required dementia policies to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Broadwell Plymouth Senior Livi
3025 North Harbor Lane
Plymouth, MN 55447
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37869

Risk:
License:
Expires on:
CFPM: KRISTINE SCHELL
CFPM #: FM69143; Exp: 02/11/2026

Inspection Info

Report Number: F8087251010
Inspection Type: Full - Single
Date: 5/20/2025 Time: 9:30:00 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH REGIONAL DIRECTOR KIM BENDICKSON

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8087251010 from 5/20/2025

John Boettcher

KRISTINE SCHELL
DIRECTOR OF CULINARY SERVICES

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Broadwell Plymouth Senior Livi
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F8087251010
Inspection Type: Full
Date: 5/20/2025
Time: 9:30:00 AM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Walk-in Cooler at 33 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT TOMATO**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SOUP**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Walk-in Freezer at 1 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Refrigerator at 34 Degrees F.
Comment: **#2**
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: Refrigerator at 36 Degrees F.
Comment: **#2**
Violation Issued?: No

New Record: **Product/Item/Unit:** CUT LFY GRN**; Temperature Process:** Cold-Holding
Location: Refrigerator at 38 Degrees F.
Comment: **#2**
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CUT TOMATO**; Temperature Process:** Cold-Holding
Location: Refrigerator at 37 Degrees F.
Comment: **#2**
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHOW MEIN**; Temperature Process:** Hot-Holding
Location: Serving Line at 159 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** RICE**; Temperature Process:** Hot-Holding
Location: Serving Line at 163 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** DELI MEAT**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 33 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CUT TOMATO**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 32 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHEESE**; Temperature Process:** Cold-Holding
Location: Prep Rail at 33 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Freezer at 14 Degrees F.
Comment: **#2**
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Refrigerator at 33 Degrees F.
Comment: **#4**
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** DRESSING**; Temperature Process:** Cold-Holding
Location: Refrigerator at 33 Degrees F.
Comment: **#4**
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Broadwell Plymouth Senior Livi
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F8087251010
Inspection Type: Full
Date: 5/20/2025
Time: 9:30:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 163 Degrees F.
Comment:
Violation Issued?: No