Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378691462M
Compliance #: HL378692344C

Date Concluded: April 28, 2025

Name, Address, and County of Licensee Investigated:
Broadwell Senior Living
3025 Harbor Lane North
Plymouth, MN 55447
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Substantiated, individual responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator financially exploited the resident when he cashed two $1,000.00 checks from the resident's bank account for his own use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP accepted and cashed two $1,000.00 checks from the resident. The AP failed to refuse the checks and failed to report the incidents to management despite his training on maltreatment and not accepting gifts.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's power of attorney (POA) and family member. The investigator contacted law enforcement.

The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report and related facility policy and procedures. Also, the investigator observed staff cleaning a resident's room and the resident in her apartment.

The resident resided in an assisted living facility. Her diagnoses included dementia and mild cognitive decline. The resident's service plan included medication management and administration. Staff provided assistance and cueing with dressing. The resident could make her needs known and was oriented to person, place and time. The nurse assessed her as vulnerable in the area of financial assessment and unable to independently manage her finances. The resident had a family member who was her POA and representative.

While reconciling the resident's checkbook one weekend, her POA came across two checks for $1,000.00 each, written to a person whose name the POA did not recognize. The POA asked another family member if they recognized the name on the checks; they did not. The POA went to the facility and asked a supervisor if he recognized the name written on the checks and determined the person was an employee at the facility. The supervisor said it was the AP's name on both checks. He worked as an unlicensed personnel and provided direct cares to the resident.

The supervisor reported the incident to senior management. They started an internal investigation and contacted law enforcement.

Review of the resident's cashed checks indicated two checks, eight days apart, were written to the AP both in the amount of $1000.00.

During an interview, the POA said she was upset with the resident but did not talk to her about the checks because she would not remember writing them. The POA said last Christmas the resident talked about planning to give an unnamed staff member a few thousand dollars. Her intentions were reported to nursing and no money was given to staff members. The POA said she wanted the resident to have financial independence and dignity to the extent she could with her diagnoses. Letting her have some checks seemed safer than cash because the POA could trace checks. The POA said she did not know the circumstances or details on why the AP received the two $1,000.00 checks. She declined to press charges since the AP no longer worked at the facility.

The AP's personnel file records indicated he was trained on vulnerable adults, maltreatment, and not accepting gifts.

The AP did not respond to a scheduled phone interview. He did not respond to email and subpoena interview requests.

The former executive director did not respond to interview requests.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The AP did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Attempted.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP did not respond to interview requests.

Action taken by facility:
The facility contacted law enforcement. The facility contacted the AP about the incident and he is no longer employed there.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment.

To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Plymouth City Attorney
Plymouth Police Department

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 _____	C 04/09/2025

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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL378692344C/HL378691462M On April 9, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 57 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL378692344C/HL378691462M, tag identification 2360.	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 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 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 evaluators' 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 SUBDIVISION 1-3.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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 _____	C 04/09/2025

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
02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		