

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL378692042M  
**Compliance #:** HL378693448C

**Date Concluded:** July 29, 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:** Lena Gangestad, RN  
Special Investigator

**Finding:** Substantiated, facility 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 facility neglected the resident when the nurse failed to perform a full head-to-toe assessment, and the unlicensed personnel (ULP) failed to notify the nurse about the scab on the resident's toes.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for maltreatment. The facility failed to ensure proper care and communication among staff. The nurse did not perform a full head-to-toe assessment, which is essential for identifying potential health issues early. Additionally, the ULP failed to report a visible scab on the resident's toes, preventing timely medical attention.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigation included review of the resident's records, transitional care record, hospital record and facility policy and procedures.



The resident lived in an assisted living facility and was diagnosed with Raynaud's syndrome (a condition where the hands and feet blood vessels narrow in response to cold or stress). Her service plan included assistance with all activities of daily living, including weekly showers.

Progress notes indicated the resident previously lived independently but experienced a fall, resulting in hospitalization and a subsequent discharge to a transitional care unit (TCU). A registered nurse (RN) conducted a pre-assessment visit at the TCU four days prior to readmission.

The medical record from the TCU indicated the resident had scabs from the fall prior to her admission on the left 2nd, 3rd, and 4th toes, as well as on the right big toe, 2nd, and 3rd toes. The resident readmitted to the assisted living facility on the 24<sup>th</sup> day of the month.

The resident's initial assessment was completed on the day of admission (the 24th), and the 14-day follow-up assessment was conducted on the 31st. All assessments, including the pre-assessment conducted on the 20th, noted small healing scabs on the resident's right and left knees only, which were open to air and healing. Nothing was mentioned about the scabs on her feet.

According to service records, the resident received weekly showers between the 25th of the month and the 8th of the following month. All were provided by the same ULP.

On the 15th of the following month, progress notes indicated the resident complained of foot pain. Upon assessment, the RN observed the second toe on the resident's left foot was necrotic, swollen, and severely ulcerated. The toe appeared hard and white. Additional ulcers were noted on the third toe, and small scabs were found throughout both feet. The right foot had various scabs on the toes, and the left foot was pink and swollen.

Hospital records indicated the resident admitted later that same day (the 15th) with a diagnosis of gangrene in the second toe of her left foot. She underwent a below-the-knee amputation the next day.

During an interview, the ULP stated she noticed scabs on the resident's second and third toes on both feet while assisting with a shower, just one day after the resident admitted to the facility. She said she asked the resident about the scabs, and the resident replied they were from a fall and were healing, stating there was no need to notify the nurse. The ULP said that was why she chose not to report the condition.

During an interview, the RN confirmed she conducted the pre-assessment at the TCU and recalled checking the resident's skin but could not remember if she removed the resident's socks at the time. She stated during the 14-day assessment, the resident had not reported any pain, and she did not notice anything unusual about the feet. The RN only discovered the



wound when the resident later complained of foot pain. At that point, she removed the socks and observed the severe wound.

In conclusion, the Minnesota Department of Health determined neglect 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.

**Neglect: Minnesota Statutes, section 626.5572, subdivision 17**

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

**Vulnerable Adult interviewed:** no, unable to reach.

**Family/Responsible Party interviewed:** Yes.

**Alleged Perpetrator interviewed:** Not Applicable.

**Action taken by facility:**

After the resident reported pain, the nurse assessed the wound and implemented appropriate interventions.

**Action taken by the Minnesota Department of Health:**

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. 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>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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  
Minnesota Board of Nursing



Minnesota Department of Health

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |                                                   |
|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>37869 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                    | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/02/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BROADWELL PLYMOUTH SENIOR LIVING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3025 NORTH HARBOR LANE<br>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                                                                | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL378692042M/HL378693448C</p> <p>On June 2, 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 97 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for HL378692042M/HL378693448C, tag identification 1620, 2360.</p> | 0 000                                                           | <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p> |                    |                                                   |
| 01620<br>SS=G                                                        | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 01620                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |                                                   |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                          |  |                                                   |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>37869 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/02/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BROADWELL PLYMOUTH SENIOR LIVING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3025 NORTH HARBOR LANE<br>PLYMOUTH, MN 55447                                    |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| 01620                                                                | <p>Continued From page 1</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.</p> <p>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive head-to-toe reassessment for one of one resident (R1) reviewed. Additionally, the licensee failed to ensure unlicensed personnel (ULP) notified the nurse of any observed skin abnormalities, for an RN to assess a change. R1's existing toe wounds worsened, developing gangrene and R1 was hospitalized.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety,</p> | 01620                                                           |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                          |  |                                                   |
|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>37869 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/02/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BROADWELL PLYMOUTH SENIOR LIVING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3025 NORTH HARBOR LANE<br>PLYMOUTH, MN 55447                                    |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| 01620                                                                | <p>Continued From page 2</p> <p>not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 admitted to the facility on March 24, 2025. R1's service agreement indicated R1 received assistance with all activities of daily living, including weekly showers.</p> <p>R1's progress notes dated March 21, 2025, indicated R1 previously lived independently but experienced a fall, resulting in hospitalization and a subsequent discharge to a transitional care unit (TCU). RN-C conducted a pre-assessment visit at the TCU on March 20, 2025.</p> <p>R1's TCU wound assessment dated February 21, 2025, indicated R1 had scabs from the fall prior to her admission on the left 2nd, 3rd, and 4th toes, as well as on the right big toe, 2nd, and 3rd toes.</p> <p>R1's preadmission assessment dated March 20, 2025, initial assessment dated March 24th, 2025, and the 14-day assessment dated March 31st, 2025, all indicated the RN noted small healing scabs on R1's right and left knees only, which were open to air and healing. The assessments lacked information or observation of the scabs on her feet.</p> <p>R1's service records printed June 2, 2025, indicated R1 received weekly showers between March 25, 2025 through April 8, 2025. All were</p> | 01620                                                           |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                          |  |                                                   |
|----------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>37869 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br>C<br>06/02/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>BROADWELL PLYMOUTH SENIOR LIVING |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3025 NORTH HARBOR LANE<br>PLYMOUTH, MN 55447                                    |  |                                                   |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                          |
| 01620                                                                | <p>Continued From page 3</p> <p>provided by ULP-D.</p> <p>R1's progress notes dated March 24, 2025 through April 14, 2025, lacked any reported concerns or observations of R1's toes after her readmission since her wound assessment at the TCU.</p> <p>R1's progress notes dated April 15, 2025, indicated R1 complained of foot pain. Upon assessment, RN-C observed the second toe on R1's left foot was necrotic, swollen, and severely ulcerated. The toe appeared hard and white. Additional ulcers were noted on the third toe, and small scabs were found throughout both feet. The right foot had various scabs on the toes, and the left foot was pink and swollen.</p> <p>R1's hospital records dated April 15, 2025, indicated R1 admitted later on April 15th, 2025, with a diagnosis of gangrene in the second toe of her left foot. She underwent a below-the-knee amputation the next day.</p> <p>On June 18th, 2025, at 1:05 p.m., ULP-D stated she noticed scabs on R1's second and third toes on both feet while assisting with a shower, just one day after R1 admitted to the facility. She said she asked R1 about the scabs, and R1 replied they were from a fall and were healing, stating there was no need to notify the nurse. ULP-D stated that was why she chose not to report the condition.</p> <p>On June 18th, 2025, at 12:55 p.m., RN-C stated she conducted the pre-assessment at the TCU and recalled checking R1's skin but could not remember if she removed R1's socks at the time. She stated that during the 14-day assessment, R1 had not reported any pain, and she did not</p> | 01620                                                           |                                                                                                                          |  |                                                   |



Minnesota Department of Health

|                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                           |                                                                                                                          |  |                                                                    |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37869</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROADWELL PLYMOUTH SENIOR LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3025 NORTH HARBOR LANE<br/>PLYMOUTH, MN 55447</b>                            |  |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                                           |
| 01620                                                                       | <p>Continued From page 4</p> <p>notice anything unusual about the feet. RN-C only discovered the wound when R1 later complained of foot pain on April 15, 2025. At that point, she removed the socks and observed the severe wound.</p> <p>The licensee policy titled, Comprehensive Resident Assessments, Monitoring and Reassessment, dated April 2021, indicated abnormal signs and symptoms, or changes in condition, are reported to a community RN who will update resident's assessments and discuss changes with resident and/or resident's authorized representative, physician or any other health care provider as needed.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>                   | 01620                                                                     |                                                                                                                          |  |                                                                    |
| 02360                                                                       | <p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by:<br/>The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p> | 02360                                                                     | No plan of correction is required for this tag.                                                                          |  |                                                                    |



Minnesota Department of Health

|                                                                             |                                                                                                                              |                                                                           |                                                                                                                          |                          |                                                                    |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>37869</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/02/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROADWELL PLYMOUTH SENIOR LIVING</b> |                                                                                                                              |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3025 NORTH HARBOR LANE<br/>PLYMOUTH, MN 55447</b>                            |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
|                                                                             |                                                                                                                              |                                                                           |                                                                                                                          |                          |                                                                    |