Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378699122M
Compliance #: HL378697462C

Date Concluded: April 16, 2025

Name, Address, and County of Licensee Investigated:
Broadwell Senior Living
3025 Harbor Lane N 307
Plymouth, MN 55447
Hennepin County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: Inconclusive

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 resident #1 and resident #2 when she stole their money.

Investigative Findings and Conclusion: The Minnesota Department of Health determined financial exploitation was inconclusive. The investigation found there was insufficient evidence to determine if the financial exploitation occurred.

The investigator conducted interviews with family member. The investigation included review of the resident's record, internal investigation documentation, incident reports, personnel files, staff schedules, policies, and procedures.

Resident #1 resided in an independent living facility. Resident #1 did not receive nursing services. He opted out of bi-weekly housekeeping and had meals at the facility daily.

Resident #2 resided in an independent living facility. Resident #1 did not receive nursing services. He received bi-weekly housekeeping and ate some meals at the facility.

Resident #1 reported during an interview with the manager that he noticed $1,800 in cash was missing at the end of January. He discovered the money was gone when he went to access his safe to pay his personal housekeeper. According to Resident #1, he always left his apartment door unlocked and kept his safe key hidden in a white bowl. He stated that while he was in the hallway, he saw the AP (a facility housekeeper), who asked if she could take out his trash. He agreed and gave her the key. She was the last person in his apartment before he realized the money was missing.

Resident #2 also reported to staff that $600 in cash was missing from his apartment. He could not recall the exact date it went missing. He stated that, to his knowledge, the only person who had been in his apartment around the time of the loss was AP, the same facility housekeeper.

The AP's employment was terminated by the facility due to unrelated reasons in middle of January.

There were no surveillance cameras near the apartments of Resident #1 and Resident #2 nor in the adjacent hallways.

A police report indicated Resident #1 told an officer that the lock on his safe required a key, which he typically kept in a bowl above one of his cabinets. On the day he discovered the theft, he found the key lying on the counter and realized that $1,800–$1,900 in $100 bills was missing from the safe and he was unsure of the exact amount. The same document indicated he said last time he saw the money was in mid-January. He also said that his personal housekeeper, who had worked for him twice a month for the past two years, was the last person inside his apartment, followed by AP. He recalled the AP had asked to take out his trash sometime in early January, and he gave her the key.

The police report also indicated that Resident #2 was interviewed and indicated he said he kept two wallets, one containing $1,000 and another with $600. He noticed that $600 in $100 bills was missing. The same document inodiated he said he received housekeeping services from the AP every other week and remembered that approximately two to three weeks ago, he was out for over an hour on a walk while AP was cleaning his apartment. He could not provide a specific period for when the money went missing.

During an interview, resident #1's family member stated that she was unsure of the exact amount of money stolen but she became aware of the incident after it had occurred and noted the police were unable to take further action due to a lack of evidence, resulting in the case being closed.

During an interview, the AP stated she could not recall the exact date of her last shift at the facility. She stated she was not R1's regular housekeeper and had only filled in once to clean his room. She had not seen the safe in R1's room and did not know where it was located. Regarding resident #2, she said she was his regular housekeeper; however, since he was new to the facility, she had only cleaned his room twice. She stated resident #2 did not allow her to clean his room unless he was present, and she had never seen his wallet. The AP denied taking money from either resident.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility started internal investigation and called law enforcement.

Action taken by the Minnesota Department of Health: No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 03/27/2025

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 On March 27th, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL378699122M/HL378697462C . No correction orders are issued.	0 000		