Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303172462M
Compliance #: HL303174267C

Date Concluded: May 30, 2025

Name, Address, and County of Licensee Investigated:
Mill Street Residence
802 South Mill Street
Fergus Falls, MN 56537
Otter Tail County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

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 facility did not assess the resident's change in condition after a fall.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident fell and was assessed by the nurse. When the resident began complaining of pain, the nurse assessed the resident and made an appointment for them to be seen by a provider. X-rays were completed and a fracture was ruled out. When the resident began having pain again almost two weeks later, the resident was reassessed then sent to the emergency room where she was diagnosed with a stress fracture.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigation included review of the resident record, hospital records, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's disease, osteoarthritis, and rheumatoid arthritis. The resident's service plan included assistance with bathing and medication administration. The resident's assessment indicated the resident was mostly independent with activities of daily living and could ambulate independently in her apartment.

Facility documentation indicated the resident was trying to sit in a chair when it rolled away from her, and she fell. The resident was assessed, and the primary care provider was updated. The resident did not have any documented injuries or complaints of pain at that time. Three days later, the resident complained of hip pain and that she felt the pain was from her fall. The nurse was notified, and the resident was reassessed. The nurse made an appointment for the resident to be seen by her primary care provider the same day. X-rays of the resident's hip and pelvis were completed and showed no fracture or dislocation. 13 days later, the resident reported hip pain again and asked to be sent to the emergency room. The resident was diagnosed with a sacral insufficiency fracture, a type of stress fracture common in people with osteoporosis caused by normal stress or everyday activities. After two days in the hospital, the resident returned to the facility.

During an interview, a facility nurse stated the resident did not have any complaints of pain immediately after the fall and as soon as she said she had pain, they had her seen at the clinic. The facility nurse stated the resident did not have any complaints of ongoing pain in between her clinic and emergency room visits and the facility had followed its protocol. The facility nurse stated the resident was able to voice concerns to staff and she would have alerted staff if she had frequent pain or any change in condition.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

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: Unavailable

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action required.

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
	30317	A. BUILDING: _____ B. WING _____	C 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL STREET RESIDENCE	802 SOUTH MILL STREET FERGUS FALLS, MN 56537

(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 May 21, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL303172462M/#HL303174267C. No correction orders are issued.	0 000		