Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305845202M
Compliance #: HL305841820C

Date Concluded: November 10, 2025

Name, Address, and County of Licensee Investigated:
Countryside Assisted Living Facility
650 El Dorado St.
Owatonna, MN 55060
Steele County

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

Evaluator's Name: Lena Gangestad, 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 it did not to provide the resident appropriate monitoring and follow-up regarding medication administration when the resident refused medications and/or deceived the facility she was taking the medications but was not.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident refused her prescribed clozapine (an antipsychotic) for several days, which resulted in hospitalization. When the concern for refusal arose, the facility notified the resident's physician and guardian appropriately.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of the resident's records, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses schizoaffective disorder. The resident's service plan included assist with medication administration.

The resident's assessment indicated a history of medication noncompliance and frequent nonadherence to treatment, which had previously resulted in worsening psychosis, including delusions and paranoia.

A concern was identified when a staff member reported the resident had refused to take her prescribed clozapine for three consecutive days.

The Medication Administration Record (MAR) indicated the resident was prescribed clozapine 325 mg nightly, consisting of 200 mg, 100 mg and 25 mg tablets, to be taken by mouth at bedtime. The physician's order allowed administration between 7:00 p.m. and 9:30 p.m. If the resident refused the medication, staff were required to notify the nurse immediately. Staff were also instructed to perform a mouth check after administration to ensure the medication was swallowed. Per physician instruction, if a dose was missed, it was permissible to administer the missed evening dose the following morning and resume the regular dosing schedule thereafter.

The resident's service plan directed staff to bring the pill cards to the resident's room and allow her to remove the medication from the card. It also required staff to complete a mouth check to verify the resident had swallowed her medication and to notify nursing staff immediately of any refusals. In addition, the service plan indicated the physician and the resident's guardian must be notified as soon as possible when the resident refused her clozapine. If the resident refused the medication for two consecutive evenings, she was to be hospitalized for dose titration. If the resident refused Emergency Medical Services (EMS) transport, staff were instructed to contact the guardian for authorization to override the president's refusal and arrange transport to the emergency room.

The resident's progress note on the fifteenth of the month indicated the nurse notified the resident's guardian the resident had refused clozapine for the two previous nights. The physician was also updated that same day. The resident's vital signs were within normal limits, and she came to the dining room for meals, appearing in a good mood and denied any paranoid or negative thoughts. The physician ordered if the resident refused clozapine again, staff were to notify the guardian and send the resident to the emergency room via ambulance for evaluation.

On the seventeenth, the resident's notes indicated the nurse again notified the guardian the resident had refused clozapine for three consecutive nights on the thirteenth, fourteenth, and fifteenth. The notes indicated the resident had refused two of her scheduled doses the previous evening, saying the medication upset her stomach. Later that evening, the resident was transported to the emergency room per the physician's order.

The hospital record indicated the resident was admitted due to noncompliance with clozapine and lorazepam for at least five days prior to admission. Two days after hospitalization, hospital staff found two baggies filled with pills in the resident's pockets. Many of the pills appeared to have been licked or partially dissolved, making identification difficult; however, one of the identified pills was clozapine.

During an interview, a county worker stated she learned about the incident from the resident's guardian. She said the resident went three to four days without taking her medications and was subsequently admitted to the hospital. The county worker also said the resident had lived at the facility for more than ten years and generally did well in that environment. She stated the facility communicated appropriately with the guardian regarding the resident's medication refusals.

During an interview, a manager stated she was not working directly with the resident but had assigned one of her nurses to monitor the situation closely. She said the nurse notified the pharmacy, the physician, and the guardian about the resident's medication refusals. The manager stated the resident eventually admitted to the hospital due to refusing her medications. The manager stated the hospital informed the facility they had discovered a bag containing unidentified medications in the resident's possession, and the hospital was unable to determine where the medications originated. Following the incident, the facility provided staff additional education on proper mouth-check procedures, including instructing staff to ask the resident to open her mouth and move her tongue from side-to-side to ensure medications were swallowed during each administration.

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: no, the resident refused.
Family/Responsible Party interviewed: no, unable to reach the guardian.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility: The facility notified the guardian and the physician in a timely manner. Following the incident, the facility took steps to reduce the risk of unknown medication refusals including education and re-training focused on performing thorough mouth checks during medication administration.

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
	30584	A. BUILDING: _____ B. WING _____	C 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CATERED SENIOR LIV	650 EL DORADO STREET OWATONNA, MN 55060

(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 September 12, 2025, the Minnesota Department of Health initiated an investigation of complaints #HL305845202M/HL305841820C. No correction orders are issued.	0 000		