Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305969423M
Compliance #: HL305963504C

Date Concluded: May 5, 2026

Name, Address, and County of Licensee Investigated:
Garden Court Chateau
2495 Southwest 8th Street
Grand Rapids, MN, 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Angela Vatalaro, 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 they failed to provide scheduled services. The resident was hospitalized. The resident developed a pressure wound.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility issued a termination of service notice related to the resident's ordered catheter flushes which exceeded services the facility provided. During the termination process, the resident was informed of service limitations. The facility coordinated with an outside homecare agency and pursued alternative placement for the resident. Alternative placement was identified that would have supported the resident's care prior to a missed catheter flush, however the resident declined placement. When the resident had a change in condition, the resident transferred to the emergency room for evaluation and hospitalized. Hospital records indicated the resident had a red blanchable area to the sacrum/coccyx. The area of skin was not open; it was red and tender.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff. The investigation included review of the resident records, hospital records, homecare records, termination of services records, related facility policy and procedures. Also, the investigator observed staff interactions with the resident and staff providing the resident services.

The resident resided in an assisted living facility. The resident's diagnoses included multiple sclerosis, neurogenic bladder (loss of bladder control and urinary dysfunction) catheter-associated urinary tract infection (UTI), and history of sepsis. The resident's service plan included assistance with repositioning, catheter care, toileting, and transferring. The resident was unable to walk. The resident's assessment indicated at times the resident would often decline repositioning and would call during night hours to assist as she deemed needed. The resident had an indwelling catheter managed by homecare. The resident required gentamicin flushes (used for chronic bacteriuria, recurrent UTI's neurogenic bladder, long term catheter use) to the catheter five times a week. Homecare assisted twice weekly with possibility up to three times weekly. The resident had an increase in catheter changes due to increased sediment causing occlusion. The resident was oriented to person, place, time, was occasionally disoriented with intermittent confusion, worsening memory and recalling events accurately.

The resident's facility pre-termination meeting summary indicated the resident required [medicated] flushes due to sediment involving the resident's catheter placed a safety concern on the resident. The facility was not staffed 24/7 with licensed nurses to perform the task. The facility did not maintain onsite registered nurse (RN) coverage seven days a week nor did it provide catheter flushes on its Uniform Disclosure of Assisted Living Services and Amenities (UDALSA). The facility made arrangements to meet the resident's level of care until a transfer to higher level of care was available.

The resident's termination notice indicated the resident's medical needs had increased to include five times a week of indwelling catheter flushes, original being seven times a week. The facility provided scheduled on-call nursing support but did not provide or maintain on-site RN coverage seven days a week, nor did it include skilled nursing procedures such as catheter flushes. The notice indicated the resident's continued residence without daily RN care presented a significant risk to the resident of catheter occlusion, infection, and hospitalization.

During the timeframe in question, records indicated prior to the missed catheter flush alternate placement for a skilled nursing facility was offered to meet the resident's needs, and this was communicated to the resident and involved parties. The facility did not receive a response.

The resident medication administration record (MAR) indicated the resident had gentamicin flushes for her catheter ordered five days a week. The facility coordinated with an outside homecare agency for catheter flushes. The homecare agency provided the flushes on Tuesdays,

Thursdays and Fridays. Facility nurses and the homecare agency provided the flushes as ordered up to the time of the missed flushes over holidays.

During the timeframe in question, the resident's MAR indicated the resident did not receive a gentamicin flush on a Wednesday (a holiday), Thursday (a holiday), or Friday.

On Thursday, homecare records indicated the agency was scheduled to provide the flush.

Progress notes indicated the facility followed up to inquire if the agency came on Thursday. The agency stated they were not available to come that day and informed the resident's representative of the omission.

On Friday, progress notes indicated the homecare agency did provide the resident's flush. That same evening, records indicated the resident transferred to the emergency room for a fever and diarrhea. The resident was hospitalized.

Hospital records indicated the resident had a fever, diarrhea, and was hospitalized for severe sepsis secondary to catheter associated urinary tract infection. The reason for the resident's hospital stay was recurrent bladder infection from chronic foley catheter. While hospitalized the resident's diarrhea and sepsis improved. Records indicated in regard to the gentamicin flushes they could not quantify the number of infections or occlusions that were prevented with the gentamicin flushes, and they were discontinued. Records also indicated resident had a red blanchable area on her sacrum/coccyx, but no open pressure wound.

The resident was hospitalized for five days and discharged back to the facility.

The resident's records indicated the resident's catheter flushes discontinued and the resident's termination of services was rescinded by the facility.

During an interview, a nurse stated the resident was having recurrent issues related to the resident's catheter and occlusions. The facility did not provide catheter flushes. The nurse said facility nurses, in coordination with a homecare agency, were providing flushes during the termination process. The resident's proposed placement options were declined. Prior to the timeframe in question, the nurse stated the facility communicated to the parties involved that they would not have a facility nurse at the facility on the holiday [Wednesday] and notified the resident and family there would be omissions.

During an interview, leadership stated the resident was offered multiple different placement options for a higher level of care due to the catheter flushes prior to the resident's hospitalization, but those were declined. The flushes had since discontinued, the termination was rescinded, as the resident's services fell back into the scope of services the facility provided.

During an interview, the resident stated there was no open area on her sacrum/coccyx when she was hospitalized. The area was red and tender.

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

Action taken by facility:
The facility communicated with the resident and involved parties that the ordered catheter flushes exceeded the facility’s scope of services. The facility communicated with the provider and involved parties regarding service limitations. Efforts were made to coordinate with skilled/homecare agencies to meet the resident’s needs. The resident was monitored for changes in condition and sent to the hospital as condition changed. The facility made efforts to identify other placement capable of meeting the resident’s increased catheter management needs. The facility communicated the resident’s needs, associated risks, and service limitations.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	C 04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

(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: HL305963504C/HL305969423M On April 8, 2026, 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 23 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL305963504C/HL305969423M, tag identification 0430.	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.	
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of	0 430		

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0 430	Continued From page 1 license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to update the Uniform Disclosure of Assisted Living Services and (UDALSA) identifying services the licensee does not provide for one of one residents (R1) with records reviewed. The UDALSA did not specifically identify the licensee's limitations with cathether flushes. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 430		

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0 430	Continued From page 2 The licensee provided Uniformed Disclosure of Assisted Living Services and Amenities (UDALSA) dated December 1, 2024, indicated the licensee provided indwelling urinary catheter care, emptying and bag change, suprapubic catheter care, and straight (intermittent) catheter assistance services. The licensee's UDALSA did not identify specific limitations the licensee had related to catheter flushes. R1 admitted to the licensee October 21, 2016. R1's diagnoses included multiple sclerosis, neurogenic bladder, catheter-associated urinary tract infections. R1's service plan dated September 19, 2025, indicated R1 received catheter care two times per day. A Pre-Termination Meeting Summary dated October 27, 2025 in which R1 and others were present, indicated the licensee issued a pre-termination notice to R1 due to an increase in sediment involving the resident's catheter, required flushes due to sediment build up, and occlusions as ordered by a Urologist. This placed a safety concern as the facility was not staffed 24/7 with licensed nurses to perform the task. The licensee explained during the meeting that R1's chronic catheter and comorbid diagnoses are the cause of the increase in sediment. The current order from the urologist indicated five times a week of flushes. The licensee needed to take into consideration if R1's bladder was not draining urine into the catheter bag and as needed flush/changes also needed to be anticipated. The licensee reviewed the UDALSA and identified services the licensee provided specific to catheter care of emptying and changing the catheter bag. The licensee indicated unlicensed personnel cannot be trained/or delegated to provide catheter flushes. The	0 430		

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0 430	Continued From page 3 licensee discussed recommendations of the need for R1 to have a higher level of care with licensed nurses available 24/7 to meet the resident's chronic catheter needs. The licensee discussed how the homecare agency cannot come more than two times a week, nor on holidays, nor weekends. The licensee reviewed risks being placed on R1, that not having availability of flushes as needed, the risk of occlusion and/or sepsis due to not draining properly and backing up into the kidneys. The licensee reviewed that they were currently making arrangements to meet R1's level of care need as required until a higher level of care was available. R1's termination notice dated November 5, 2025, indicated R1's medical needs had increased to now include five times week of indwelling catheter flushes, original being seven times a week. This procedure constitutes a skilled nursing service, as it requires nursing assessment, sterile technique, and ongoing monitoring by a registered nurse (RN) to maintain catheter patency and prevent infection. The facility operated under the UDALSA, that defines the scope of services available. The facility provided scheduled and/on call support but did not maintain on-site RN coverage seven days per week, nor did it include daily skilled nursing procedures such as catheter flushing on its licensed and disclosed scope. R1's continued residence without daily RN care presented a significant risk to R1 of catheter occlusion, infection, and hospitalization. During an interview, on April 24, 2026, at 10:30 a.m., RN-A stated the licensee did not provide catheter flushes and issued R1 a termination of services notice. RN-A stated the licensee's UDALSA did not indicate the licensee provided	0 430		

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0 430	Continued From page 4 catheter flushes. RN-A stated catheter care included cleaning the peri-area and emptying the catheter bag. During an interview, on April 24, 2026, at 11:14 a.m., director of operations (DOO)-B stated the licensee started R1's termination process because catheter flush services were outside of the scope on their UDALSA. Catheter care on their UDALSA meant emptying the bag, changing out the catheter bag, wiping off and cleaning to reduce risk of infection. DOO-A stated it was basic catheter care. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		