Electronically Delivered

November 5, 2025

Licensee
Garden Court Chateau
2495 Southwest 8th Street
Grand Rapids, MN 55744

RE: Project Number(s) SL30596016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

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 _____	10/16/2025

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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30596016-0 On October 13, 2025, through October 16, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility license.	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. 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=E	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide documentation to support the minimum frequency of inspections, maintenance, and load tests had been met for the emergency power generator as	0 680		

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0 680	Continued From page 4 part of the emergency plan to ensure proper performance of the generator. This had the potential to directly affect all building occupants. 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 16, 2025, at 10:00 a.m., the surveyor toured the facility with director of business development (DBD)-I. During the facility tour, the surveyor observed an emergency power generator. During an interview on October 16, 2025, at approximately 11:45 a.m., the surveyor requested weekly inspection and monthly load test records. DBD-I stated maintenance had been performing weekly generator inspections and load tests, but this documentation had not been recorded. The licensee failed to provide documentation to support the minimum frequency of inspections, maintenance, and load tests meeting the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator: - Records for weekly inspections of the generator systems were not provided.	0 680		

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0 680	Continued From page 5 - Monthly load test records were not provided. - Records of monthly transfer switch operation tests were not provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants. 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 16, 2025, at 10:00 a.m., the surveyor toured the facility with director of business development (DBD)-I. During the facility tour, the	0 775		

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0 775	Continued From page 6 surveyor observed the following: CARBON MONOXIDE ALARMS/DETECTION Carbon monoxide alarms were not installed within ten feet of all resident sleeping rooms. On October 16, 2025, director of business development (DBD)-I, licensed assisted living director in residency/registered nurse (LALDIR/RN)-A, and clinical nurse supervisor (CNS)-B provided a copy of the fire alarm inspection report dated September 11, 2025. Record review of the available documentation indicated carbon monoxide detectors were not tied into the building fire alarm system to sound an alarm notifying building occupants of the presence of carbon monoxide. During an interview on October 16, 2025, at 12:05 p.m., DBD-I verified the above listed carbon monoxide observations and documentation. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. EXIT DOORS Sliding screen doors were installed on two emergency exit doors. All paths of egress escape must be maintained free of obstruction. During the facility tour interview on October 16, 2025, DBD-I verified the exit door observations. ELECTRICAL In occupied resident room 10, an extension cord was plugged into a powerstrip, to provide power to a compact refrigerator, creating a fire hazard. During the facility tour interview on October 16, 2025, DBD-I verified the extension cord observations. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 7 days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the	0 780		

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0 780	Continued From page 8 potential to directly affect all building occupants. 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 was 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: On October 16, 2025, at 10:00 a.m., the surveyor toured the facility with director of business development (DBD)-I. During the facility tour, the surveyor observed the following: - When the smoke alarms in resident bedrooms were tested by DBD-I, none of the other dwelling unit smoke alarms were actuated. - When the smoke alarms outside the sleeping areas for rooms 1-7 and 18-24 were tested by DBD-I, none of the other dwelling unit smoke alarms were actuated. During the facility tour interview, DBD-I verified the above listed smoke alarm observations. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 9 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required drills. This had the potential to	0 810		

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0 810	Continued From page 10 directly affect all building occupants. 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 was 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: On October 16, 2025, director of business development (DBD)-I, licensed assisted living director in residency/registered nurse (LALDIR/RN)-A, and clinical nurse supervisor (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with site specific procedures for the facility and building occupants. - The plan inaccurately referenced an ANSUL system and monitored fire alarm system. - The FSEP floor plan used red dots for emergency exit doors. Emergency exits must be clearly labeled in order to direct occupants to the designated exits in the event of an emergency. - The FSEP included standard employee procedures, but failed to provide employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. - The FSEP included standard resident	0 810		

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0 810	Continued From page 11 evacuation procedures, but failed to provide site specific actions for resident movement and evacuation or relocation during a fire or similar emergency evident by a lack of these procedures in the plan. During an interview on October 16, 2025, at 11:45 a.m., DBD-I verified the FSEP was lacking. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees at a frequency of every other month evident by fire drill documentation lacking the required frequency. Evacuation drill logs from December 2024 to October 2025 were requested by the surveyor. Fire drills were recorded in March, April, May, July, and September 2025. Fire drills were not conducted between December 2024 and February 2025. During an interview on October 16, 2025, at 12:05 p.m., LALDIR/RN-A and CNS-B verified the evacuation fire drill frequency was not met during the change in ownership transition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01750		

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01750	Continued From page 12 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for two of seven residents (R2, R5) whose medication administration was delegated to unlicensed personnel (ULP). 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R2 R2's diagnoses included diabetes, cerebrovascular accident, and anxiety.	01750		

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01750	Continued From page 13 R2's Addendum to Contract- Waiver- MN (Minnesota) (service plan) dated August 26, 2025, indicated R2's services included medication administration four times per day. R2's prescriber orders dated June 18, 2025, included an order for ammonium lactate 12% apply topically to affected area(s) twice daily. R2's Med (medication) Admin (administration) Summary- Date Range dated September 2025, and October 2025, respectively, indicated ammonium lactate 12% apply topically to affected area(s) twice daily. On October 14, 2025, at 9:13 a.m., the surveyor observed ULP-F apply approximately a pea size amount of ammonium lactate 12% to R2's face, top of head, legs, and feet. During the observation, ULP-F stated R2's ammonium lactate was used for dry skin areas. R2's record lacked resident specific instructions for the administration of where to apply ammonium lactate 12%. R5 R5's diagnoses included mild dementia, hypertension (HTN- high blood pressure), and diabetes. R5's Addendum to Contract- Waiver- MN service plan dated September 22, 2025, indicated R5's services included medication administration seven times per day. R5's prescriber orders dated April 1, 2025, included an order for diclofenac (Voltaren) 1% apply 4 grams (g) topically to shoulder and knee four times a day.	01750		

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01750	Continued From page 14 R5's Med Admin Summary- Date Range dated September 2025, and October 2025, respectively, indicated diclofenac Sodium 1% gel apply 4g topically to shoulder and knee four times a day. On October 14, 2025, at 7:57 a.m. the surveyor observed ULP-F apply approximately a grape size amount of diclofenac sodium 1% gel to both of R5's knees. R5's record lacked resident specific instructions for the administration of which knee and shoulder to apply the diclofenac sodium 1% gel. On October 14, 2025, at 11:43 a.m., ULP-F stated R2 and R5's electronic medication administration record (EMAR) did not indicate specific areas to apply medications to, however, ULP-F was aware of where to apply each topical cream or gel. ULP-F further stated R5 does not have diclofenac 1% gel applied to R5's shoulder until 12:00 p.m. On October 14, 2025, at 2:42 p.m., LALDIR/RN-A stated licensed nurses transcribed prescriber orders onto the resident's EMAR. LALDIR/RN-A further stated the resident EMAR was supposed to include specific instructions on what areas to apply topical creams or gels, however, R2 and R5's EMAR lacked the specific area of where to apply the topical cream or gel. The licensee's Medication and Treatment Management Plan(s) policy dated August 1, 2021, indicated the EMAR will include medication, diagnosis, side effects, and specific instructions for resident. No further information was provided.	01750		

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01750	Continued From page 15 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of seven residents (R5) observed during medication administration. 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 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).	01760		

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01760	Continued From page 16 The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R5's diagnoses included mild dementia, hypertension (HTN- high blood pressure), and diabetes. R5's Addendum to Contract- Waiver- MN (Minnesota) (service plan) dated September 22, 2025, indicated R5's services included medication administration seven times per day. R5's prescriber orders dated April 1, 2025, included an order for diclofenac (Voltaren) 1% apply 4 grams (g) topically to shoulder and knee four times a day. R5's Med (medication) Admin (administration) Summary- Date Range dated September 2025, and October 2025, respectively, indicated diclofenac sodium 1% gel apply 4g topically to shoulder and knee four times a day. On October 14, 2025, at 7:57 a.m. the surveyor observed unlicensed personnel (ULP)-F apply approximately a grape size amount of diclofenac sodium 1% gel to both of R5's knees. The surveyor did not observe ULP-F use a dosing card to verify 4g of diclofenac sodium 1% gel. On October 14, 2025, at 11:41 a.m., ULP-F stated R5's diclofenac sodium 1% gel no longer had a dosing card available to measure out 4g of	01760		

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01760	Continued From page 17 gel, however, ULP-F knew approximately how much to give from previous administrations. ULP-F further stated ULP-F had not reported R5's dosing card for diclofenac sodium 1% gel was missing to licensed staff. On October 14, 2025, at 2:40 p.m., CNS-B stated ULPs were supposed to use the dosing card that came in the box with R5's diclofenac sodium 1% gel, and CNS-B was not aware the dosing card was unable to be located. CNS-B further stated after each use of the dosing card, ULPs were trained to clean the dosing card, and place the dosing card back into the box. The manufacturer's instructions for Voltaren (diclofenac sodium) dated July 2009, indicated the proper amount of Voltaren Gel should be measured using the dosing card supplied in the drug product carton. In addition, the dosing card should be used for each application of drug product. The licensee's Medication Administration-Procedure policy dated August 1, 2021, indicated to follow the six rights of medications including the right dose. The licensee's Medication Error(s) policy dated August 1, 2021, indicated to contact a licensed nurse and explain the situation in detail with the medication name, dosage, and amount given as well as the resident involved. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01800	Continued From page 18	01800		
01800 SS=D	144G.71 Subd. 11 Prescribed and nonprescribed medication The assisted living facility must determine whether the facility shall require a prescription for all medications the provider manages. The facility must inform the resident whether the facility requires a prescription for all over-the-counter and dietary supplements before the facility agrees to manage those medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to determine whether the licensee shall require a prescription for all over-the counter (OTC) medications provided by the assisted living staff prior to managing the medication for one of seven residents (R8). 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 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). The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R8 was admitted to the assisted living facility on	01800		

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01800	Continued From page 19 October 6, 2025. R8's diagnoses included cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD- difficult breathing), and diabetes. R8's Addendum to Contract- Private- MN (Minnesota) (service plan) dated October 6, 2025, indicated R8's services included medication administration five times per day. R8's Master Care Plan dated October 8, 2025, indicated R8 was unable to safely self-administer medications, and non-narcotic medications were locked in a medication cart, medication room, or medication refrigerator. On October 14, 2025, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R8's scheduled morning medication. The surveyor observed a bottle of Desitin Maximum Strength (used for minor skin irritations or diaper rash) placed on R8's bed side table. ULP-F stated a family member must have brought in the bottle of Desitin for R8. R8's record lacked a prescriber order for Desitin Maximum Strength. On October 15, 2025, at 12:50 p.m., LALDIR/RN-A stated the licensee required a prescriber order for all over the counter medications and the licensee was awaiting to receive R8's standing orders. CNS-B further stated CNS-B was not aware R8 had Desitin in R8's and the Desitin would require a prescriber order prior to staff administering Desitin to R8. The licensee's Medication and Treatment Orders policy dated August 1, 2021, indicated written	01800		

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01800	Continued From page 20 prescriber's order must be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01800		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secured and permitted access to only authorized personnel for one of seven residents (R10). This had the potential to affect all residents receiving refrigerated medications. In addition, the licensee failed to ensure one of one refrigerator storing medications stored medications according to manufacturer's recommended temperature. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01880		

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01880	Continued From page 21 The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. MEDICATION SECURITY R10's Treatment and Therapy Plan- Assessment dated October 14, 2025, indicated non-narcotic medications were locked in a medication cart, medication room, or medication refrigerator. On October 14, 2025, at 9:27 a.m., the surveyor observed unlicensed personnel (ULP)-F administered R10's scheduled morning medication. ULP-F administered R10's Novolog insulin, returned to the medication cart in the dining room, placed the Novolog insulin pen on top of the cart (accessible to any staff, residents, or visitors), and walked away from the medication cart. During the observation, the surveyor observed several residents and family members in the dining room conversating and eating breakfast. On October 14, 2025, at 11:51 a.m., ULP-F stated ULP-F was trained to ensure all medications were locked in the medication cart when not in use, and ULP-F did not know why ULP-F had left R10's insulin pen on the top of the medication cart instead of placing the insulin pen in the locked medication drawer. On October 14, 2025, at 3:04 p.m., CNS-B and LALDIR/RN-A stated resident medications should never be left on the medication cart or	01880		

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01880	Continued From page 22 unattended. CNS-B further stated ULPs were trained to place medications back into the secured medication cart after use. MEDICATION STORAGE On October 14, 2025, at 11:27 a.m., the surveyor observed the secured medication refrigerator with ULP-F. ULP-F stated the current temperature of the medication refrigerator was 38 degrees Fahrenheit (F) and the temperature was recorded daily by ULPs. The medication refrigerator included the following medications: -37 unopened stock acetaminophen 650 milligrams (mg) suppositories; -12 unopened bisacodyl 10 mg suppositories for R10; and -six unopened bisacodyl 10 mg suppositories for R3. The licensee's Facility Temperatures- By Type dated September 14, 2025, through October 14, 2025, indicated the medication refrigerator temperature was checked daily with the temperatures documented between 41 degrees F up to 43 degrees F. The licensee failed to provide documentation of acetaminophen and bisacodyl suppositories were stored according to manufacturer's instructions. On October 14, 2025, at 2:55 p.m., CNS-B stated medications should be stored according to instructions provided by the manufacturer. CNS-B further stated the licensee could access manufacturer's instructions on the licensee's electronic medical documentation system to review what temperature suppositories were supposed to be stored at. The manufacturer's instructions for	01880		

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01880	Continued From page 23 acetaminophen suppository dated February 2025, indicated to store acetaminophen suppositories between 68 degrees F to 77 degrees F or in a cool place. The manufacturer's instructions for bisacodyl suppository dated November 21, 2022, indicated to store bisacodyl suppositories at room temperature between 59 degrees F to 86 degrees F. The licensee's Storage of Medications policy dated August 1, 2021, indicated medications managed outside of a residents' private "living space" must be securely locked and substantially constructed compartments and permit only authorized personnel to have access. In addition, medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890		

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01890	Continued From page 24 review, the licensee failed to ensure medications were maintained with the original prescription label in two of two medication carts (South, North). 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 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). The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. On October 14, 2025, at 11:20 a.m., the surveyor reviewed the locked South medication cart with unlicensed personnel (ULP)-F and observed 29 unopened vials of Ipratropium Bromide/Albuterol 0.5 milligram (mg)/ 3 mg in a box without a prescription label. ULP-F stated the box did not have a prescription label and "assumed" they were for an unidentified resident. On October 14, 2025, at 11:34 a.m., the surveyor reviewed the locked North medication cart with ULP-F and observed 60 unopened vials of DuoNeb in a box without a prescription label. ULP-F stated the box lacked a prescription label and thought the vials were for a resident residing in apartment eight. ULP-F further stated all	01890		

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01890	Continued From page 25 medications, including boxed medications, were supposed to have a prescription label attached. On October 14, 2025, at 3:02 p.m., CNS-B stated when ULPs recognized medication supplies were running low, the ULP would remove the prescription label off of the box and place it in the top drawer of the medication cart to remind staff to reorder the medication. CNS-B further stated ULPs were supposed to document any low medication orders on the medication reorder sheet. In addition, all prescriptions were to be stored with a prescription label. The licensee's Medication Administration-Procedure policy dated August 1, 2021, indicated the labels of all medication bottles will be neat and legible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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 _____	10/16/2025

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

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01910	Continued From page 26 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. 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 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). The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. The licensee's Discharged Resident/Client Roster dated April 1, 2025, through October 13, 2025, indicated R1 was admitted to the facility on July 8, 2025, and discharged on August 29, 2025.	01910		

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01910	Continued From page 27 R1's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD- difficult breathing), and hypertension (HTN- high blood pressure). R1's Addendum to Contract- Private- MN (Minnesota) (service plan) dated August 12, 2025, indicated R1 received medication administration four times per day. R1's Med (medication) Admin (administration) Summary- Actual- Month dated July 2025, and August 2025, respectively, indicated R1 received or was prescribed the following medications: -levothyroxine (for underactive thyroid) 50 micrograms (mcg) daily -metolazone (for HTN) 2.5 milligrams (mg) daily -Anoro Ellipta (for breathing) 62.5-25 mcg one inhalation daily -carvedilol (for HTN) 25 mg twice daily -divalproex sodium (for bipolar) 250 mg three times daily -doxazosin (for bladder) 2 mg twice daily -furosemide (for edema) 40 mg twice daily -isosorbide mononit Er (for CHF) 30 mg daily -lisinopril (for HTN) 30 mg daily -Miralax (for constipation) 17 grams daily -quetiapine (for depression) 25 mg daily -Tramadol (for pain) 25 mg twice daily -Vitamin D3 (supplement) 1,000 units daily -lorazepam (for anxiety) 2 mg four times daily -Lasix (for edema) 20 mg as needed -Eliquis (to prevent blood clots) 2.5 mg twice daily -Compazine (for nausea/vomiting) take one tablet every eight hours as needed -DuoNeb (for shortness of breath) 3 milliliter (mL) every four hours as needed -Seroquel (for depression) 75 mg daily -Haldol (for agitation, restlessness, anxiety) 0.5	01910		

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01910	Continued From page 28 mg every two to four hours as needed -Nitrostat (for chest pain) 1 tablet every five minutes as needed R1's prescriber orders dated July 8, 2025, August 25, 2025, and August 26, 2025, respectively, included the above noted medications. R1's Discharge Care Plan dated August 29, 2025, indicated R1 was deceased on August 29, 2025, under the care of hospice. R1's Medication Disposition-Resident dated January 30, 2023, through October 13, 2025, respectively, listed the above noted medications, however, lacked Compazine, Eliquis, Lasix, DuoNeb, lorazepam, Seroquel, Tramadol, and Haldol's prescription number. On October 14, 2025, at 2:31 p.m., CNS-B stated the licensee was aware prescription numbers were required documentation for medication disposition, however, the medications noted above were R1's medications from home and the prescription number were not entered into the licensee's online medical record system when R1 was admitted. The licensee's Disposal of Medication policy dated August 1, 2021, indicated for unused prescription drugs (medications) upon disposition the assisted living provider must document in the resident medication destruction record the disposition of the medication including the prescription number as applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-F) observed administering medications. 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 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). The findings include: During the entrance conference on October 13, 2025, at 11:50 a.m., licensed assisted living director in residency/registered nurse (LALDIR/RN)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R7's diagnoses included chronic obstructive	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 30 pulmonary disease (COPD-difficult breathing), congestive heart failure (CHF), and hypertension (HTN- high blood pressure). R7's Addendum to Contract- Waiver- MN (Minnesota) (service plan) dated September 15, 2025, indicated R7's services included medication administration five times per day. R7's prescriber orders dated June 25, 2025, included an order for Salmeterol (Wixela) (for COPD) 500-50 micrograms (mcg) inhaler one puff by mouth twice daily. Rinse mouth after each use. R7's Med (medication) Admin (administration) Summary- Date Range dated September 2025, and October 2025, respectively, indicated R7 was administered Wixela 500-50- inhale one puff twice daily. Rinse and spit after use. On October 14, 2025, at 8:33 a.m., the surveyor observed ULP-F provide scheduled morning medication administration for R7. ULP-F handed R7 the Wixela, R7 inhaled one puff from the Wixela, and handed the Wixela back to ULP-F. The surveyor did not observe ULP-F offer R7 water to rinse and spit after inhalation of Wixela. On October 14, 2025, at 11:46 a.m., ULP-F stated usually R7 was eating breakfast while receiving medications and would rinse and spit after the Wixela administration, however, ULP-F did not offer R7 to rinse and spit after Wixela this morning (October 14, 2025). On October 14, 2025, at 2:46 p.m., CNS-B stated ULPs were trained to offer residents to rinse and spit after administration of Wixela every time, even if the resident typically refused to rinse and	02320		

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02320	Continued From page 31 spit water after administration. The manufacturer's instructions for Wixela dated March 2023, indicated to rinse mouth with water after breathing in Wixela. Spit out the water. Do not swallow it (water). The licensee's Medication Administration-Procedure policy dated August 1, 2021, indicated to offer/provide a drink to rinse mouth after inhaler use. The licensee's Medication Administration-Services Provided by ULP policy dated August 1, 2021, indicated a RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. In addition, the ULP must demonstrate their ability to competently follow the delegated medication administration to a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

GARDEN COURT CHATEAU
2495 SW 8TH STREET
Grand Rapids, MN 55744
Itasca County
Parcel:

Phone:

License Info

License: HFID 30596

Risk:
License:
Expires on:
CFPM: WANDA RAITER
CFPM #: CFPM50521; Exp: 2-6-2028

Inspection Info

Report Number: F7939251153
Inspection Type: Full - Single
Date: 10/14/2025 Time: 5:50:40 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery:

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: DRY STORAGE 1 FRIDGE WAS HOLDING AT 45F. ALL SAUCES WERE TOSSED OUT AND PASTEURIZED (EGGS AND MILK) ITEMS MOVED TO FRIDGES THAT WERE HOLDING BELOW 41F
Comply By: 10/14/2025 Originally Issued On: 10/14/2025

! **New Order: 4-100 Equipment Construction Materials**
4-101.11A *Priority Level: Priority 1 CFP#: 47*
MN Rule 4626.0450A Remove all unsafe multi-use equipment, utensils, and food storage containers that impart color, odors or tastes to food.
COMMENT: ENAMELWARE COOKING BINS ARE NOT APPROVED AND WILL CHIP. CONTAINERS WERE LEFT ON THE COUNTER AND CASSIE WAS INFORMED TO REMOVE THEM FROM THE KITCHEN.
Comply By: 10/14/2025 Originally Issued On: 10/14/2025

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: FRIDGE IN STORAGE ROOM 1 IS NOT APPROVED AND INTERIOR IS WALLS ARE CRACKED, FRIDGE WAS REMOVED FROM KITCHEN.
Comply By: Complied On Site Originally Issued On: 10/14/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: ESTABLISHMENT DID NOT HAVE ANY WAY OF TESTING THE CHLORINE SANITIZER IN THE WHIPPING CLOTH BUCKET
Comply By: 10/28/2025 Originally Issued On: 10/14/2025

Food & Beverage General Comment

DISCUSSION
REHEATING AFTER FALLING BELOW 135F TO 165F BEFORE SERVICE
GLOVE USE AND HAND WASHING
EQUIPMENT MAINTENANCE

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F7939251153 from 10/14/2025

CASSIE GRENIGER
COOK

Ryan Trenberth,
Public Health Sanitarian 3
218-308-2133
ryan.trenberth@state.mn.us

Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

GARDEN COURT CHATEAU
Grand Rapids
County/Group: Itasca County

Inspection Info

Report Number: F7939251153
Inspection Type: Full
Date: 10/14/2025
Time: 5:50:40 AM

Food Temperature: Product/Item/Unit: COLE SLAW DRESSING**; Temperature Process:** Cold-Holding
Location: Upright Cooler dry storage 1 at 45 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: butter**; Temperature Process:** Cold-Holding
Location: upright Cooler dry storage 2 at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ranch dressing**; Temperature Process:** Cold-Holding
Location: kitchen cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: turkey**; Temperature Process:** Re-Heating
Location: stovetop at 194 Degrees F.
Comment: oven went out and turkey was reheated to >165f within 2hrs
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
710 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

GARDEN COURT CHATEAU
Grand Rapids
County/Group: Itasca County

Inspection Info

Report Number: F7939251153
Inspection Type: Full
Date: 10/14/2025
Time: 5:50:40 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Greater Than** 160F Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No