Electronically Delivered

May 15, 2026

Licensee
Heritage Cottage on 6th
611 West 6th Street
Park Rapids, MN 56470

RE: Project Number(s) SL26536016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2026, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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 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: SL26536016 On March 30, 2026, through April 3, 2026, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 32 residents, 23 of whom were receiving services under the provider's Assisted Living with Dementia Care 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 License Providers. 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 surveyors' 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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. 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 observation on March 31, 2026, at 09:05 a.m., with a computer being held by unlicensed personnel (ULP)-B's left ungloved hand, ULP-B walked to R5's apartment and knocked on the door with their right ungloved hand. ULP-B waited	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 510	Continued From page 2 for R5 to state that it was alright for ULP-B to enter. With the right ungloved hand, ULP-B opened R5's door and entered the apartment. ULP-B explained she would be assisting R5 with insulin administration. R5 verbalized understanding. ULP-B walked to the kitchen cabinet area and placed the laptop onto the counter. ULP-B obtained a set of keys from her pocket with their right ungloved hand and proceeded to open a cabinet that held R5's medications and insulin administration supplies, including alcohol wipes, a Glargine insulin pen, an Aspart insulin pen, and insulin pen needles. ULP-B placed a pair of gloves onto both hands. ULP-B did not wash their hands with soap and water or use any type of hand sanitizer to cleanse their hands. ULP-B opened the laptop computer and began to login to the medication administration record (MAR) system with the right gloved hand. ULP-B then obtained a needle from the insulin supply container and while holding the Glargine insulin pen with the left gloved hand, removed the cover of the insulin and placed an insulin needle with the right gloved hand onto the insulin pen. ULP-B dialed the Glargine insulin pen to 2 units and depressed the pen to release the 2 units of insulin into the cover of the needle. ULP-B proceeded to dial the Glargine insulin to 40 units and then placed the insulin pen onto the counter of the kitchen cabinet. ULP-B compared the MAR to the insulin pen and proceeded to compare R5's blood glucose result to the Aspart insulin sliding scale dosing schedule. ULP-B obtained the Aspart insulin with their gloved left hand, removed the cover of the pen and placed an insulin pen needle onto the Aspart insulin pen using their right gloved hand. ULP-B dialed the Aspart insulin pen to 2 units and depressed the pen to release the 2 units of insulin into the covered insulin pen needle. ULP-B then dialed	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 510	Continued From page 3 the Aspart insulin pen to 6 units and placed the pen onto the counter of the kitchen cabinet. With their right gloved hand, ULP-B proceeded to touch the laptop computer keyboard and verified the dose of Aspart insulin to be administered. ULP-B proceeded to gather the supplies using their gloved hands and proceeded to go into the living area where R5 was seated in a chair. ULP-B explained they would be administering R5's insulin which R5 verbalized understanding. With their right gloved hand, ULP-B obtained an alcohol wipe and proceeded to wipe R5's upper left quadrant stomach area with the alcohol wipe. ULP-B removed the insulin needle cover on the Glargine insulin needle. ULP-B proceeded to administer the Glargine insulin to the upper left quadrant area on R5's abdomen that had been cleansed with the alcohol wipe. After administering the Glargine insulin, ULP-B removed the needle from R5's upper left quadrant area of the abdomen and proceeded to place the cover of the needle onto the Glargine insulin pen. ULP-B obtained an alcohol wipe and proceeded to wipe R5's lower left quadrant abdominal area with the alcohol wipe. ULP-B removed the insulin needle cover on the Aspart insulin needle. ULP-B proceeded to administer the Aspart insulin to the area on R5's lower left quadrant abdominal area that had been cleansed with the alcohol wipe. After administering the Aspart insulin, ULP-B removed the needle from R5's lower left quadrant abdominal area and proceeded to place the cover of the needle onto the Aspart insulin pen. ULP-B placed both the insulin pens into their right gloved hand. ULP-B returned to the kitchen area, removed the needles from each of the insulin pens and placed the needles into a hazardous waste container. ULP-B removed their gloves and proceeded to type on the laptop keyboard with both hands. ULP-B returned the insulin	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 510	Continued From page 4 supplies to the medication cabinet using ungloved hands. ULP-B closed the door to the medication cabinet with their right ungloved hand, obtained the keys in their pants pocket, and proceeded to lock the door with their ungloved right hand. ULP-B then obtained the laptop from the kitchen counter with their ungloved left hand and opened the door using their ungloved right hand and exited R5's apartment after asking if there was anything else R5 needed. ULP-B stopped in the hallway to speak with clinical nurse supervisor (CNS)-A. After speaking with CNS-A, ULP-B returned to the nursing office, opened the door with their ungloved right hand, went to the desk in the office and sat in a chair. ULP-B opened the laptop with their right ungloved hand and proceeded to type on the keyboard with both ungloved hands. ULP-B did not wash their hands with soap and water or use any type of hand sanitizer to cleanse thier hands. During interview on March 30, 2026, at 9:25 a.m., ULP-B stated she viewed training videos on hand washing, glove use, and insulin administration when she was hired May 8, 2024. ULP-B stated CNS-A had demonstrated the process of hand washing and insulin administration and ULP-B was competency tested by CNS-A to ensure ULP-B performed hand washing and insulin administration correctly. On March 30, 2026, at 12:05 p.m., CNS-A stated all ULPs were required to watch training videos through Relias (an online training platform), observe CNS-A performing the delegated task and CNS-A would ensure staff were performing the delegated tasks before they were able to work on their own. The licensee's Hand Washing policy dated	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 510	Continued From page 5 January 1, 2026, indicated hand washing would be performed to prevent the spread of infection to other personnel, residents, and visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents. 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).	0 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 700	Continued From page 6 The findings include: On March 31, 2026, at 10:25 a.m., a binder containing resident medical records was observed on a shelf in the north kitchen of the licensee's secure assisted living area. The binder was unsecured and visible, allowing access to residents' personal information that lived on the north side of the licensee's secured assisted living. The binder contained private medical information, including resident specific health information, which was not protected from unauthorized access. Also observed was a communication book used to document resident concerns during caregiver working shifts on the north side of the secure assisted living. Caregivers had documented resident information in the communication books using residents' personal names. On March 31, 2026, at 10:28 a.m., a binder containing resident medical records was observed on a shelf in the south kitchen of the licensee's secure assisted living area. The binder was unsecured and visible, allowing access to residents' personal information that lived on the south side of the licensee's secured assisted living. The binder contained private medical information, including resident specific health information, which was not protected from unauthorized access. Also observed was a communication book used to document resident concerns during caregiver working shifts on the south side of the secure assisted living. Caregivers had documented resident information in the communication books using residents' personal names. During interview on March 31, 2026, at 11:35 a.m., clinical nurse supervisor (CNS)-A stated the	0 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
0 700	Continued From page 7 binders were used for staff reference and acknowledged that the records were kept in the kitchen areas for convenience. CNS-A also acknowledged the records were not secured and could be accessed by others. The licensee's Security of Resident Records policy dated December 1, 2021, indicated all information in the resident record would be kept confidential and accessible only to authorized personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
01500	Continued From page 8 disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
01500	Continued From page 9 least eight hours of annual training for each twelve months of employment for one of one employee (unlicensed personnel (ULP)-B). 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: ULP-B had a hire date of May 8, 2024. ULP-B's employee records lacked any evidence of annual training. During interview on March 30, 2026, at 1:55 p.m., licensed assisted living director (LALD)-C stated ULP-B had not completed any annual training. LALD-C also stated that ULP-B was currently working on her education but did not have any record of ULP-B completing any of the required annual education. The licensee's Annual Training polic, dated January 23, 2024, indicated all direct care employees would complete eight hours of annual education training for twelve months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

HERITAGE COTTAGE ON 6TH
611 WEST 6TH STREET
Park Rapids, MN 56470
Hubbard County
Parcel:

Phone:

License Info

License: HFID 26536

Risk:
License:
Expires on:
CFPM: CRISTINE JAKUBEK
CFPM #: FM57807; Exp: 04/21/2028

Inspection Info

Report Number: F8045261043
Inspection Type: Full - Single
Date: 3/30/2026 Time: 11:45:05 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS FACILITY OPERATES TWO SERVING KITCHENS AND ALL FOODS ARE CATERED. NO FOOD PREP OCCURS IN THE SERVING KITCHENS.

SERVING KITCHENS FOUND CLEAN AND IN GOOD CONDITION AT TIME OF INSPECTION.

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 F8045261043 from 3/30/2026

Establishment Representative

Adam J Bommersbach

Adam Bommersbach,
Public Health Sanitarian 3
218-308-2147
adam.bommersbach@state.mn.us

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

HERITAGE COTTAGE ON 6TH
Park Rapids
County/Group: Hubbard County

Inspection Info

Report Number: F8045261043
Inspection Type: Full
Date: 3/30/2026
Time: 11:45:05 AM

Food Temperature: Product/Item/Unit: CHICKEN BREAST**; Temperature Process:** Receiving
Location: Warmer at 160 Degrees F.
Comment: COTTAGES KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment: COTTAGES KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: SCALLOPED POTATOES**; Temperature Process:** Hot-Holding
Location: Warmer at 161 Degrees F.
Comment: THE MANOR KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 34 Degrees F.
Comment: THE MANOR KITCHEN
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

HERITAGE COTTAGE ON 6TH
Park Rapids
County/Group: Hubbard County

Inspection Info

Report Number: F8045261043
Inspection Type: Full
Date: 3/30/2026
Time: 11:45:05 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 50 PPM
Comment: COTTAGES KITCHEN
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment: THE MANOR KITCHEN
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 160 Degrees F.
Comment: THE MANOR KITCHEN
Violation Issued?: No