Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 27, 2026

Administrator
EMMANUEL NURSING HOME
1415 MADISON AVENUE
DETROIT LAKES, MN 56501

RE: CCN: 245489
Cycle Start Date: April 3, 2026

Dear Administrator:

On April 3, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 27, 2026

Administrator
EMMANUEL NURSING HOME
1415 MADISON AVENUE
DETROIT LAKES, MN 56501

Re: Reinspection Results
Event ID: 22C991-H2

Dear Administrator:

On May 1, 2026, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 3, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 14, 2026

Administrator
EMMANUEL NURSING HOME
1415 MADISON AVENUE
DETROIT LAKES, MN 56501

RE: CCN:245489

Cycle Start Date: April 3, 2026

Dear Administrator:

On April 3, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department

of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 3, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 3, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will

not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308   Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 14, 2026

Administrator
EMMANUEL NURSING HOME
1415 MADISON AVENUE
DETROIT LAKES, MN 56501

Re: State Nursing Home Licensing Orders
Event ID: 22C991-H1

Dear Administrator:

The above facility survey was completed on April 3, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us

Office: (320) 223-7318 Mobile: (320) 216-5631

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245489**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS On 4/1/26, through 4/3/26, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was not in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H54899741C (2966171) with no deficiency issued. Deficient practice was identified related to incidental findings at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in e POC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F0000		04/29/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	F 689 Free of Accident Hazards/Supervision/Devices How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. (R 3) was safely transferred to her chair. Education to (NAR-A) was given immediately on policy that includes ensuring that there is a clear unobstructed path for the lift machine. Verbal education given to NAR to not step away from the resident while lowering/lifting or when patient is standing in the machine. How will the facility identify other residents having the potential to be affected by the same practice. Education to all team members that use the mechanical lifts, on policy to ensure staff are	04/29/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501

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F0689 SS = D	Continued from page 1 Based on observation, interview and document review, the facility failed to ensure a safe transfer for 1 of 3 residents (R3) reviewed for accidents when staff failed to stay next to R3 while in the stand lift and staff walked away from the stand lift to move wheelchair out of the way. . Findings include: R3’s annual Minimum Data Set (MDS) dated 3/11/26, identified R3’s cognition was moderately impaired with no behaviors. R3 required substantial/moderate assistance with activities of daily living including all transfers. Once standing R3 was dependent upon staff to walk 10 feet with walker and used manual wheelchair for mobility. R3’s active diagnoses included progressive neurological condition, osteoporosis (causes bones to become weak and brittle), dementia, Parkinson’s disease (a movement disorder of the nervous system that worsens over time and may cause stiffness, slowing of movement and trouble with balance that raises the risk of falls), malnutrition, anxiety disorder, depression, and history of falls without injury. R3 received antipsychotic and antidepressant medications. R3’s care plan dated 3/16/26, identified:Activities of daily living (ADL) performance deficit and risk for impaired range of motion (ROM) due to limited mobility. Staff were directed to transfer with assist of one-to-two with patient assist lift (PAL) (mechanical lift used to assist resident to stand from seated position and lower to a seated position when standing) up to dependent (DEP) help with PAL and all transfers. Use two staff assist and/or Hoyer (portable total body) lift when weak or lethargic. Limited physical mobility due to disease process related to Parkinson’s disease and dependent upon staff for wheelchair use. Staff were directed to assist with mobility as needed and follow recommendations from therapy. Ambulate straight distances in hall with front wheeled walker (FWW), gait belt, followed by wheelchair and two staff assist. Do not ambulate if lethargic.Potential for communication problems, soft spoken usually understood/understands but does wax and wane over the course of the day related to her disease process and fatigue level. Staff were directed to provide a safe environment, assistive devices, adaptive equipment, and brakes locked on bed and wheelchair as much as possible.At risk for falls: gait/balance problems due to Parkinson’s disease and dystonia (a movement disorder caused by muscles to contract that are not under the person’s control), potential for poor safety awareness, sensory deficits, vision/hearing, potential for side effects (SE) of	F0689	Continued from page 1 following guidelines to transfer residents safely. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Education to team members, that use the mechanical lifts, on policy to ensure staff are following guidelines to transfer residents safely. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audit on mechanical lift transfers will be conducted weekly x 4 weeks, then monthly x 3 months. After completion of audits, it will be reviewed by the QAPI team and determined if additional audits are necessary based on findings. Responsible Persons: Nurse Manager’s/ADON/DON Date corrected: 4/29/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245489**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501**

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F0689 SS = D	Continued from page 2 medications especially psychotropic medications, and history of benign paroxysmal vertigo (a sudden feeling of spinning or moving, loss of balance or not being steady, nausea/vomiting, brought on by change in head position or standing/walking). Staff were directed to not leave alone in wheelchair in room, provide a safe environment, and anticipate and meet resident's needs.Parkinson's Disease affecting her physical and mental health. Staff were directed to use and provide adaptive devices recommended by therapy and observe for safe and appropriate use. Observe and report any signs/symptoms of medication side effects (SE) such as dizziness, somnolence, confusion, impaired vision.R3's progress notes dated 3/8/26 at 2:17 p.m., R3 had a vasovagal response (a type of fainting, a temporary loss of consciousness that happens when the vagal nerve is overstimulated, blood pressure drops, become unsteady, and could happen with little or no warning) while on toilet this a.m. Became very weak/pale. Assisted with transfer (t/f) once she was more alert and in recliner. R3's annual fall risk assessment dated 2/26/26, identified use of walker, wheelchair, gait disturbance/unsteady gait, and poor trunk control. Balance during transitions and walking, not steady, only able to stabilize with staff assistance. R3 had functional limitation, ROM, and impairment of both upper/lower sides of both upper/lower extremities. R3 has had two or more falls without injury since admission. Physical therapy (PT) evaluation and plan of treatment dated 2/26/26, identified diagnoses: Parkinson's disease with dyskinesia (uncontrollable muscle movements that can be anything from slight tremor of the hands to an uncontrollable movement of the upper or lower body extremities) fluctuations and muscle weakness. Fall risk assessment: history of five falls in the past year due to tipping forward or to the side in recliner chair. R3 felt unsteady while standing, walking and was worried about falling. During an observation on 4/2/26 at 9:20 a.m., nursing assistant (NA)-A pushed R3 in wheelchair down the hallway and pulled her backwards into her room so that she was positioned facing the doorway. NA-A pulled the EZ stand lift from bathroom, opened the legs of the lift and pushed lift to R3's wheelchair. NA-A locked the brakes of the wheelchair and the lift machine, placed a hunter green sling with black trim around R3, positioned feet on the foot plate, hooked the sling's black loops to lift, and instructed R3 to hold onto the handlebars. NA-A stood next to R3. Using the hand	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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EMMANUEL NURSING HOME	1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501

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F0689 SS = D	Continued from page 3 control, lifted R3 off the wheelchair, turned lift brakes off, pulled lift machine away from wheelchair, closed the legs of lift machine, and pushed R3 into the bathroom. NA-A positioned R3 over toilet, placed lift brakes on, pulled R3's pants down, and lowered R3 onto the toilet. NA-A removed R3's soiled brief, placed a clean brief between R3's legs, used the EZ stand to lift R3 up and off toilet, completed peri cares, pulled up brief, and released lift brakes. NA-A pulled the lift machine away from the toilet, out of the bathroom, and asked if R3 wanted to go back into wheelchair or the recliner. R3's wheelchair remained positioned in front of her recliner. R3 stated, “recliner”. R3 stood in lift machine positioned in front of a wheelchair without brakes on and with wheels facing the doorway. NA-A walked along R3's right side, behind her, around to the backside of wheelchair, pushed wheelchair over to the end of the bed (approximately a total of 10 feet away). NA-A returned to the front of the EZ stand lift. NA-A left R3 unattended, facing the doorway in the EZ stand lift unable to visualize NA-A. R3 was able to stand and continued to hold onto handles. NA-A pushed the stand lift forward, opened legs of lift, positioned R3 in front of the recliner, and lowered R3 down onto the recliner. NA-A removed sling loops from machine, pulled lift machine away, pulled legs of lift together, and removed sling belt from around R3. During an interview on 4/1/26 at 4:20 p.m., R3 stated concern about her strength and ability to stand, she felt it was difficult at times when tired. She received therapy, hoped to increase her strength, and continue to use the stand lift for transfers but was afraid of falling when standing due to being tired or weak. Staff provided assistance when needed during transfers, usually the stand lift. During an interview on 4/2/26 at 2:30 p.m., NA-A stated the brakes on the EZ stand lift were to be used when the machine was not moving. R3 was care planned for assist of one to two staff with the stand lift. Sometimes R3 was unsteady. NA-A was aware R3 had had a vasovagal response and fainted in the bathroom.. R3 was usually assist of one to transfer with stand lift, depending on how R3 felt. NA-A stated she was aware R3 had planned on going to her recliner after the bathroom and forgot to move the wheelchair out of the way. NA-A verified, R3 was left unattended in the EZ stand lift without the brakes on. R3 could have fallen and had an accident if R3 or the lift machine moved. NA-A stated she had received education on how to safely use a lift machine when hired in 8/2025, and that situation would not have been considered safe practice.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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EMMANUEL NURSING HOME	1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501

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F0689 SS = D	Continued from page 4 During an interview on 4/2/26 at 3:50 p.m., RN-B stated staff would have been expected to place EZ stand lift brakes on when not in motion with the resident in lift. RN-B stated every resident was unique and individualized, it was a reaction of the NA to go move the wheelchair, and depends on the situation. Interview on 4/3/26 at 9:16 a.m., EZ Way lift customer support representative (CSR) stated staff would be expected to stay next to the resident while up in the EZ stand lift, "You never know what they will do, to avoid an accident or fall. Staff needed to remain close to the resident. Common sense would only take two seconds for staff to let go and the resident could have fallen. Bottom line, you cannot leave a resident in a EZ stand lift and walk away, there was no way this would have been safe." During an interview on 4/3/26 at 9:45 a.m., physical therapist (PT) stated R3 had two recent episodes of Vasovagal responses in the bathroom, poor core strength, tendency for retropulsion (causes loss of balance in a backwards direction), Parkinson’s disease with poor movement pattern where her feet crisscrossed. Staff would be expected to stand next to R3 when she was up in the EZ stand lift, staff should not leave R3's side. In general, would be considered best practice for anyone completing a transfer with a lift. R3 had a standing tolerance in physical therapy of two to three minutes, with some support with balance, and a walker. Today R3 was tired and could not have tolerated standing that long. PT stated it was important for staff to stay next to R3 while in the EZ stand lift in case something happened such as another vasovagal response, R3's legs could have buckled, and slide out of the lift and fell. During an interview on 4/3/26 at 10:30 a.m., director of nursing (DON) stated R3 was at risk for falls. R3 had good days and bad days. When sleepy R3 had more difficulty when transferring from one place to another. Staff would be expected to use the brakes on the EZ stand lift when not moving, to prevent the stand from moving away and prevent falls or accidents. Either the brakes on the lift or the wheelchair should be on when lifting or lowering the resident, but only one so that there was give to the lift per the EZ Way Lift customer support representative. Staff were expected to stand near the resident while standing in the lift. When there was an obstacle in the pathway while a resident was in aN EZ lift stand, staff would be expected to lock the brakes on the lift, move the obstacle if within arm’s length or turn the call light on for assistance, so that the resident remained safe. R3’s	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501

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F0689 SS = D	Continued from page 5	F0689		

wheelchair should have been moved prior to the transfer so that it was not an obstacle and potentially placed R3 at a higher risk for a fall when the NA left R3 unattended in the stand lift to move the wheelchair.

During an interview on 4/3/26 at 12:11 p.m., registered nurse (RN)-A stated the staff would have been expected to check the path in which they would be taking prior to a transfer to another surface in an EZ stand lift. Staff would have been expected to place brakes on lift if they did not move and stay next to the resident during the transfer to prevent an accident. Last time staff completed the transfer lift competency review was June or July 2025. RN-A stated the facility policy and manufacturer's guideline were vague and lacked information regarding when the wheels of the lift should be locked and varied depending on obstacles in the room.

Facility policy Lifting Machine, Using a Mechanical reviewed 6/11/25, identified the purpose of this policy was general principles of safe lifting using a mechanical lifting device and was not a substitute for manufacturer's training or instructions. General Guidelines:

1. At least two nursing assistants are needed to safely move a resident with a mechanical lift. A standing lift may be used with one or two team members based on needs of the resident. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. Steps in the Procedure:

-Place the sling under the resident. Visually check the size to ensure it is not too large or too small.

-Lower the sling bar closer to the resident.

-Attach sling straps to sling bar, according to manufacturer's instructions.

-Make sure the sling is securely attached to the clips and that it is properly balanced.

-Check to make sure the resident's head, neck and back are supported.

-Before resident is lifted, double check the security of the sling attachment.

-Examine all hooks, clips or fasteners.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245489**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/03/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL NURSING HOME	**1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501**

(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) COMPLETION DATE
F0689 SS = D	Continued from page 6 -Check the stability of the straps. -Ensure that the sling bar is securely attached and sound. -Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. -Check the resident's comfort level by asking or observing for signs of pinching or pulling of the skin. -Slowly lift the resident. Only lift as high as necessary to complete the transfer. Raise the patient: With hand control in-hand, stand beside the patient. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. With the patient in a standing position, transfer to the desired location. Be aware of any obstacles that may inhibit the movement of the EZ Way Smart Stand. -Gently support the resident as he or she is moved, but do NOT support any weight. -When the transfer destination is reached, slowly lower the resident to the receiving surface. -Once the resident's weight is released, stop the lowering and ensure that the sling bar does not hit the resident. -Detach the sling from the lift. -Carefully remove the sling from under the resident. Be mindful of the resident's position and balance, and skin. EZ Way Smart Stand manufacturer's operator's instructions undated, identified the EZ Way Smart Stand was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary. WARNING: for safe operation of the EZ Way Smart Stand, the stand must be used by trained personnel in accordance with the operator's manual, video and training checklist to avoid injury to patient. Safety Notes: the only time you should lock the wheels of the EZ Way Smart Stand- when in use is when you are raising or lowering the patient during ambulation. EZ Way Smart Stand Competency Checklist undated,	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245489	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/03/2026

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F0689 SS = D	Continued from page 7 identified when is the only time you lock the brakes on the EZ Way Smart Stand? Answer: when footplate is removed. EZ Way Smart Stand in-service training video presented by EZ Way representative identified staff were expected to stand next to resident during lowering/lifting using hand control. During a demonstration of gait training with out foot plate on EZ Way Smart Stand representative left the side of the resident standing up while attached to the machine, placed brakes on wheels and walked away from resident and lift, moved the chair up behind the patient and stated “you would usually have an assistant.”	F0689		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/1/26, through 4/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		04/29/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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

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20000	Continued from page 1 The following complaint was reviewed: H54899741C (2966171) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	20830	corrected	04/29/2026

Minnesota State Department of Health

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20830	Continued from page 2 resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe transfer for 1 of 3 residents (R3) reviewed for accidents when staff failed to stay next to R3 while in the stand lift and staff walked away from the stand lift to move wheelchair out of the way. Findings include: R3's annual Minimum Data Set (MDS) dated 3/11/26, identified R3's cognition was moderately impaired with no behaviors. R3 required substantial/moderate assistance with activities of daily living including all transfers. Once standing R3 was dependent upon staff to walk 10 feet with walker and used manual wheelchair for mobility. R3's active diagnoses included progressive neurological condition, osteoporosis (causes bones to become weak and brittle), dementia, Parkinson's disease (a movement disorder of the nervous system that worsens over time and may cause stiffness, slowing of movement and trouble with balance that raises the risk of falls), malnutrition, anxiety disorder, depression, and history of falls without injury. R3 received antipsychotic and antidepressant medications. R3's care plan dated 3/16/26, identified:Activities of daily living (ADL) performance deficit and risk for impaired range of motion (ROM) due to limited mobility. Staff were directed to transfer with assist of one-to-two with patient assist lift (PAL) (mechanical lift used to assist resident to stand from seated position and lower to a seated position when standing) up to dependent (DEP) help with PAL and all transfers. Use two staff assist and/or Hoyer (portable total body) lift when weak or lethargic. Limited physical mobility due to disease process related to Parkinson's disease and dependent upon staff for wheelchair use. Staff were directed to assist with mobility as needed and follow recommendations from therapy. Ambulate straight distances in hall with front wheeled walker (FWW), gait belt, followed by wheelchair and two staff assist. Do not ambulate if lethargic.Potential for communication problems, soft spoken usually understood/understands but does wax and wane over the course of the day related to her disease process and fatigue level. Staff were directed to provide a safe environment, assistive devices, adaptive equipment, and brakes locked on bed and wheelchair as much as possible.At risk for falls:	20830		

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NAME OF PROVIDER OR SUPPLIER: EMMANUEL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE: 1415 MADISON AVENUE , DETROIT LAKES, Minnesota, 56501	

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20830	Continued from page 3	20830		

Continued from page 3

gait/balance problems due to Parkinson's disease and dystonia (a movement disorder caused by muscles to contract that are not under the person's control), potential for poor safety awareness, sensory deficits, vision/hearing, potential for side effects (SE) of medications especially psychotropic medications, and history of benign paroxysmal vertigo (a sudden feeling of spinning or moving, loss of balance or not being steady, nausea/vomiting, brought on by change in head position or standing/walking). Staff were directed to not leave alone in wheelchair in room, provide a safe environment, and anticipate and meet resident's needs.Parkinson's Disease affecting her physical and mental health. Staff were directed to use and provide adaptive devices recommended by therapy and observe for safe and appropriate use. Observe and report any signs/symptoms of medication side effects (SE) such as dizziness, somnolence, confusion, impaired vision.R3's progress notes dated 3/8/26 at 2:17 p.m., R3 had a vasovagal response (a type of fainting, a temporary loss of consciousness that happens when the vagal nerve is overstimulated, blood pressure drops, become unsteady, and could happen with little or no warning) while on toilet this a.m. Became very weak/pale. Assisted with transfer (t/f) once she was more alert and in recliner.

R3's annual fall risk assessment dated 2/26/26, identified use of walker, wheelchair, gait disturbance/unsteady gait, and poor trunk control. Balance during transitions and walking, not steady, only able to stabilize with staff assistance. R3 had functional limitation, ROM, and impairment of both upper/lower sides of both upper/lower extremities. R3 has had two or more falls without injury since admission.

Physical therapy (PT) evaluation and plan of treatment dated 2/26/26, identified diagnoses: Parkinson's disease with dyskinesia (uncontrollable muscle movements that can be anything from slight tremor of the hands to an uncontrollable movement of the upper or lower body extremities) fluctuations and muscle weakness. Fall risk assessment: history of five falls in the past year due to tipping forward or to the side in recliner chair. R3 felt unsteady while standing, walking and was worried about falling.

During an observation on 4/2/26 at 9:20 a.m., nursing assistant (NA)-A pushed R3 in wheelchair down the hallway and pulled her backwards into her room so that she was positioned facing the doorway. NA-A pulled the EZ stand lift from bathroom, opened the legs of the lift and pushed lift to R3's wheelchair. NA-A locked

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20830	Continued from page 4 the brakes of the wheelchair and the lift machine, placed a hunter green sling with black trim around R3, positioned feet on the foot plate, hooked the sling's black loops to lift, and instructed R3 to hold onto the handlebars. NA-A stood next to R3. Using the hand control, lifted R3 off the wheelchair, turned lift brakes off, pulled lift machine away from wheelchair, closed the legs of lift machine, and pushed R3 into the bathroom. NA-A positioned R3 over toilet, placed lift brakes on, pulled R3's pants down, and lowered R3 onto the toilet. NA-A removed R3's soiled brief, placed a clean brief between R3's legs, used the EZ stand to lift R3 up and off toilet, completed peri cares, pulled up brief, and released lift brakes. NA-A pulled the lift machine away from the toilet, out of the bathroom, and asked if R3 wanted to go back into wheelchair or the recliner. R3's wheelchair remained positioned in front of her recliner. R3 stated, "recliner". R3 stood in lift machine positioned in front of a wheelchair without brakes on and with wheels facing the doorway. NA-A walked along R3's right side, behind her, around to the backside of wheelchair, pushed wheelchair over to the end of the bed (approximately a total of 10 feet away). NA-A returned to the front of the EZ stand lift. NA-A left R3 unattended, facing the doorway in the EZ stand lift unable to visualize NA-A. R3 was able to stand and continued to hold onto handles. NA-A pushed the stand lift forward, opened legs of lift, positioned R3 in front of the recliner, and lowered R3 down onto the recliner. NA-A removed sling loops from machine, pulled lift machine away, pulled legs of lift together, and removed sling belt from around R3. During an interview on 4/1/26 at 4:20 p.m., R3 stated concern about her strength and ability to stand, she felt it was difficult at times when tired. She received therapy, hoped to increase her strength, and continue to use the stand lift for transfers but was afraid of falling when standing due to being tired or weak. Staff provided assistance when needed during transfers, usually the stand lift. During an interview on 4/2/26 at 2:30 p.m., NA-A stated the brakes on the EZ stand lift were to be used when the machine was not moving. R3 was care planned for assist of one to two staff with the stand lift. Sometimes R3 was unsteady. NA-A was aware R3 had had a vasovagal response and fainted in the bathroom.. R3 was usually assist of one to transfer with stand lift, depending on how R3 felt. NA-A stated she was aware R3 had planned on going to her recliner after the bathroom and forgot to move the wheelchair out of the way. NA-A verified, R3 was left unattended in the EZ stand lift without the brakes on. R3 could have fallen and had an	20830		

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20830	Continued from page 5	20830		

accident if R3 or the lift machine moved. NA-A stated she had received education on how to safely use a lift machine when hired in 8/2025, and that situation would not have been considered safe practice.

During an interview on 4/2/26 at 3:50 p.m., RN-B stated staff would have been expected to place EZ stand lift brakes on when not in motion with the resident in lift. RN-B stated every resident was unique and individualized, it was a reaction of the NA to go move the wheelchair, and depends on the situation.

Interview on 4/3/26 at 9:16 a.m., EZ Way lift customer support representative (CSR) stated staff would be expected to stay next to the resident while up in the EZ stand lift, "You never know what they will do, to avoid an accident or fall. Staff needed to remain close to the resident. Common sense would only take two seconds for staff to let go and the resident could have fallen. Bottom line, you cannot leave a resident in a EZ stand lift and walk away, there was no way this would have been safe."

During an interview on 4/3/26 at 9:45 a.m., physical therapist (PT) stated R3 had two recent episodes of Vasovagal responses in the bathroom, poor core strength, tendency for retropulsion (causes loss of balance in a backwards direction), Parkinson’s disease with poor movement pattern where her feet crisscrossed. Staff would be expected to stand next to R3 when she was up in the EZ stand lift, staff should not leave R3's side. In general, would be considered best practice for anyone completing a transfer with a lift. R3 had a standing tolerance in physical therapy of two to three minutes, with some support with balance, and a walker. Today R3 was tired and could not have tolerated standing that long. PT stated it was important for staff to stay next to R3 while in the EZ stand lift in case something happened such as another vasovagal response, R3's legs could have buckled, and slide out of the lift and fell.

During an interview on 4/3/26 at 10:30 a.m., director of nursing (DON) stated R3 was at risk for falls. R3 had good days and bad days. When sleepy R3 had more difficulty when transferring from one place to another. Staff would be expected to use the brakes on the EZ stand lift when not moving, to prevent the stand from moving away and prevent falls or accidents. Either the brakes on the lift or the wheelchair should be on when lifting or lowering the resident, but only one so that there was give to the lift per the EZ Way Lift customer support representative. Staff were expected to stand near the resident while standing in the lift. When

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20830	Continued from page 6 there was an obstacle in the pathway while a resident was in aN EZ lift stand, staff would be expected to lock the brakes on the lift, move the obstacle if within arm’s length or turn the call light on for assistance, so that the resident remained safe. R3’s wheelchair should have been moved prior to the transfer so that it was not an obstacle and potentially placed R3 at a higher risk for a fall when the NA left R3 unattended in the stand lift to move the wheelchair. During an interview on 4/3/26 at 12:11 p.m., registered nurse (RN)-A stated the staff would have been expected to check the path in which they would be taking prior to a transfer to another surface in an EZ stand lift. Staff would have been expected to place brakes on lift if they did not move and stay next to the resident during the transfer to prevent an accident. Last time staff completed the transfer lift competency review was June or July 2025. RN-A stated the facility policy and manufacturer’s guideline were vague and lacked information regarding when the wheels of the lift should be locked and varied depending on obstacles in the room. Facility policy Lifting Machine, Using a Mechanical reviewed 6/11/25, identified the purpose of this policy was general principles of safe lifting using a mechanical lifting device and was not a substitute for manufacturer’s training or instructions. General Guidelines: 1. At least two nursing assistants are needed to safely move a resident with a mechanical lift. A standing lift may be used with one or two team members based on needs of the resident. Lift design and operation vary across manufacturers. Staff must be trained and demonstrate competency using the specific machines or devices utilized in the facility. Steps in the Procedure: -Place the sling under the resident. Visually check the size to ensure it is not too large or too small. -Lower the sling bar closer to the resident. -Attach sling straps to sling bar, according to manufacturer’s instructions. -Make sure the sling is securely attached to the clips and that it is properly balanced. -Check to make sure the resident’s head, neck and back are supported.	20830		

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20830	Continued from page 7 -Before resident is lifted, double check the security of the sling attachment. -Examine all hooks, clips or fasteners. -Check the stability of the straps. -Ensure that the sling bar is securely attached and sound. -Lift the resident 2 inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution. -Check the resident's comfort level by asking or observing for signs of pinching or pulling of the skin. -Slowly lift the resident. Only lift as high as necessary to complete the transfer. Raise the patient: With hand control in-hand, stand beside the patient. As the patient is being raised, simultaneously tighten the safety strap buckled around their torso. With the patient in a standing position, transfer to the desired location. Be aware of any obstacles that may inhibit the movement of the EZ Way Smart Stand. -Gently support the resident as he or she is moved, but do NOT support any weight. -When the transfer destination is reached, slowly lower the resident to the receiving surface. -Once the resident's weight is released, stop the lowering and ensure that the sling bar does not hit the resident. -Detach the sling from the lift. -Carefully remove the sling from under the resident. Be mindful of the resident's position and balance, and skin. EZ Way Smart Stand manufacturer's operator's instructions undated, identified the EZ Way Smart Stand was designed to be operated safely by one caregiver. However, depending on the situation, facility policy, and the patient's condition, two caregivers may be necessary. WARNING: for safe operation of the EZ Way Smart Stand, the stand must be used by trained personnel in accordance with the operator's manual, video and training checklist to avoid injury to patient. Safety Notes: the only time you should lock	20830		

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20830	Continued from page 8 the wheels of the EZ Way Smart Stand- when in use is when you are raising or lowering the patient during ambulation. EZ Way Smart Stand Competency Checklist undated, identified when is the only time you lock the brakes on the EZ Way Smart Stand? Answer: when footplate is removed. EZ Way Smart Stand in-service training video presented by EZ Way representative identified staff were expected to stand next to resident during lowering/lifting using hand control. During a demonstration of gait training with out foot plate on EZ Way Smart Stand representative left the side of the resident standing up while attached to the machine, placed brakes on wheels and walked away from resident and lift, moved the chair up behind the patient and stated “you would usually have an assistant.” SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff were following manufacturer’s guidelines to transfer residents safely with a lift. The director of nursing or designee, should conduct measurable audits of lift transfers to ensure that processes are followed. The DON or designee should educate staff to those interventions. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		