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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Nursing Home	1415 Madison Avenue Detroit Lakes, MN 56501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE], 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 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 (continued on next page)

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 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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was more alert and in recliner.R3's annual fall risk assessment dated [DATE], 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 [NAME] 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 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 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.-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 (continued on next page)

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