STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Veterans Home	100 Delaware Veterans Blvd Milford, DE 19963

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and review of the facility's policy, the facility failed to ensure four of nine sampled residents (Resident (R) 4, R46, R8, and R41) reviewed for abuse were free from resident-to-resident physical abuse. On 07/22/25, R8 pushed R4 to the ground. As a result, R4 sustained a closed left radius fracture, a closed, displaced, comminuted right proximal humerus fracture, and a closed, displaced right distal clavicle fracture. Findings include:. 1.Review of the facility's 5-day Follow Up Report dated 07/25/25 provided by the Administrator, revealed that at the time of the incident on 07/22/25 at 5:30 PM, staff heard someone screaming. Upon entering the hallway, staff observed R4 sitting on the floor holding his head. Staff immediately ran down the hallway to investigate. The Nursing Supervisor/Registered Nurse (NS/RN) reviewed the surveillance video and noted R8 walking down the hall into R4's room. After a few seconds, R4 was seen coming out the room with R8 behind him. R8 pushed R4 to the floor. Staff immediately assessed R4, called 911 and transferred R4 to the emergency room (ER) for further evaluation. While at the hospital, R4 was diagnosed with fractures of the right shoulder and left wrist. R8 was placed on hourly safety checks as well as being seen by psych services due to some residual concerns from the incident. Review of R4's admission Record located in the R4's electronic medical record (EMR) located under the Profile tab revealed R4 was admitted to the facility on [DATE] with diagnoses of dementia with agitation, depression, anxiety, and post-traumatic stress disorder (PTSD). Review of R4's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/01/25 located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Further review revealed that R4 did not display any behaviors during the review period. Review of R4's Health Status Note dated 07/22/25 located in the EMR under the Progress Notes tab revealed that at approximately 7:05PM, staff heard loud screaming and observed R4 on the floor. The fall was unwitnessed. The resident c/o [complaint of] right shoulder pain and left wrist pain. Noted active bleeding from laceration on forehead measuring approximately 5cm [centimeter] x 1cm, and a second laceration on the nose measuring approximately 1cm x 1cm. Resident appeared clammy and diaphoretic.Resident was unable to be moved safely; nurse supervisor was notified immediately and 911 was called. EMTs [Emergency Medical Technicians] arrived approximately at 1930 [7:30PM] and transported resident to the ER for further evaluation. Review of R4's Post Fall Evaluation dated 07/22/25 located in R4's EMR under the Assessment tab revealed that on 07/22/25 at approximately 7:10 PM, R4 experienced an unwitnessed fall in the (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	hallway. At the time of the incident, the resident was ambulating in the hallway but was unable to clearly state the specific activity being performed. The cause of the fall was not immediately evident. The resident's pre-fall fall risk score was 10. Post-fall, the resident was assessed for ongoing fall risk. It was later identified that the fall was contributed to by another resident, who reportedly pushed R4, resulting in the fall. Following the incident, the resident reported constant right shoulder pain rated 10/10 [10 out of 10] .order was received to send the resident to the ER for further evaluation. Review of the hospital's After Visit Summary dated 07/24/25 located in R4's EMR under the Miscellaneous tab revealed R4 was admitted to the hospital on [DATE] with a primary diagnosis of a closed, displaced distal clavicle fracture. Further review revealed R4 also sustained a closed left distal radius fracture, and closed, displaced comminuted right proximal humerus fracture. During an interview on 3/09/26 1:43 PM, R4 stated that he was shoved down by one of the residents [R8] who came into his room. R4 stated that he wanted the resident to leave and then he shoved me down. R4 stated that he hurt his right arm and wrist and was transferred to the hospital. R4 stated that the police came into the facility to investigate. R4 stated that when he returned from the hospital, they moved him to another unit and that he has not seen the resident [R8] since. R4 stated that he was not afraid and felt safe in the facility. Review of R8's admission Record located in the R8's EMR located under the Profile tab, revealed R8 was admitted to the facility on [DATE] with diagnoses of dementia with mood disturbances, bipolar disorder, severe with psychotic features, PTSD, insomnia, and depression. Review of R8's admission MDS with an ARD of 05/28/25 revealed R8 had a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired. Further review revealed that R8 did not display any behaviors during the review period. Review of R8's comprehensive care plan initiated on 05/23/24 and last revised on 02/02/26, located in R8's EMR under the Care Plan tab revealed that R8 has a behavior problem related to bipolar disorder and dementia. R8 wanders. He refuses care at times. R8 becomes combative and has demonstrated physical aggression toward staff and others, including biting a certified nurse aide (CNA) on the shoulder and swinging his walker at a CNA. The pertinent interventions directed staff to anticipate and meet the resident's needs, divert resident by giving them alternative objects or activities, intervene as necessary to protect the rights and safety of others, and conduct safety checks every shift. On 09/27/25, the facility updated the care plan directing staff to conduct safety checks every hour. On 09/30/25 the facility updated the care plan directing staff to redirect the resident when others are in his personal space or when he is in other resident's space. Review of R8's safety checks dated 07/22/25 – 07/30/25 provided by the Administrator, revealed staff initiated and continued hourly safety checks of R8 to monitor the resident more closely. During an interview on 03/12/26 at 11: 25 PM, CNA11 stated that at the time of the incident, she was doing rounds with another CNA and helping another resident. She then heard R4 scream and noted that he was on the floor. She went to assist R4 and saw R8 coming down the hall, but she did not see what took place. After the incident, R8 was placed on hourly safety checks. During an interview on 03/12/26 at 12:51 PM, Assistant Director of Nursing (ADON) 1 stated that on 07/22/25, she just came on shift, at which time staff notified her that R4 was on the floor. She went to assess R4 and noted an abrasion on his forehead. She called 911. ADON1 stated she reviewed the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	camera footage to see what happened. She witnessed R8 walking down the hallway into R4's room and a few minutes later, R4 was seen coming out of his room with R8 behind him. R8 then pushed R4, who fell to the floor. After the incident, staff implemented hourly checks and obtained orders for psych to see R8. Additionally, they moved R4 to another unit upon his return from the hospital. During an interview on 03/12/25 at 3:21 PM, NS/RN stated that R8 was dependent upon staff for all ADLs. He is independent with ambulation with a walker and requires some cues with eating and physical assistance. NS/RN stated that R8 does get aggressive at time with care. After the incident, R8 was placed on hourly checks. 2. Review of R41's EMR Face Sheet under the profile tab revealed he was admitted on [DATE] with diagnoses from the Medical Diagnosis tab including dementia, with agitation, Alzheimer's disease with early onset, depression, restlessness and agitation, bipolar disorder, current episode depressed, severe, with psychotic features, mood [affective] disorder, major depressive disorder, recurrent severe without psychotic features, visual hallucinations, PTSD. Review of R41's EMR significant change MDS under the MDS tab with an ARD of 08/13/25 with a BIMS score that could not be determined due to resident is rarely/never understood and was severely cognitively impaired. The MDS indicated R41 had delusions, physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred one to three days, other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) behavior occurred one to three days. Review of R41's EMR Care Plan under the Care Plan tab revealed R41 was at risk for ineffective coping related to dementia with psychotic features, had behaviors like aggressiveness towards others, hallucinations, delusions, easily agitated, sitting on another residents' legs, and tends to get into others personal space. Physical Aggression Received note dated 09/27/25 revealed R8 was sitting in a chair in the dayroom when the R41 walked next to his chair and placed his hand on R8's chest. R8 punched R41 in the face with the back of his fist, which R41 responded by punching R8 in his face directly afterwards. The residents were unable to describe what happened. Review of R8's EMR Progress Notes tab revealed a Follow-up visit Psychiatric Periodic Evaluation dated 09/30/25 provided by the facility which indicated, History of Present illness. psychiatric history of Major Depressive Disorder, Post-Traumatic Stress Disorder, insomnia, and dementia, seen today for follow-up psychiatric evaluation and psychotropic medication management. During the visit. the patient was alert and cooperative with the interview. Collateral information from the nursing staff revealed a recent altercation with another resident, during which the patient reportedly placed his hand on the other resident's chest and was subsequently punched in the face. No injury reported. Staff further reported ongoing behavioral concerns, including combativeness with care, intermittent refusal of medications, and episodes of agitation. Despite these behaviors, appetite and sleep patterns have been reported as generally stable. Resident was alert and oriented to person only, had no hallucinations, and no delusions, with poor short term and long term memory, and impaired judgement. There were no other progress notes in the medical record regarding this incident. During an interview on 03/11/26 at 1:56 PM, CNA 6 stated that she has worked with R41 and has seen him be aggressive or violent towards other residents when you enter his space because he doesn't like it. He swings at staff lately but not residents. We redirect, reassure him, tell him what we are doing or trying to accomplish. He hit other people last year. Normally he does not bother unless you touch him or strike at him. R41 wanders and walked up on R8 and R8 usually does not get bothered unless you (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	invade his space. R8 pushed him and R41 pushed back. During an interview on 03/11/26 at 2:16 PM, the Activity Therapist (AT)1 stated R41 likes to be by himself, with not a lot of noise, and likes to be alone. If something is next to him, it belongs to him. If they try to take his things, he has a problem with it depending on the day. Sometimes, he verbally tells him not to touch it. We redirect other residents away from him. R41 does get into altercations with other residents because he tries to see what is going on. If I see a resident-to-resident altercation I redirect them like if I see R41 going towards other residents or touching a walker, I redirect them before things get too involved. R8 does not hit unless he is provoked. During an interview on 03/12/26 at 2:03 PM, NS/RN stated R8 had his monitoring checks increased from 1 hour to 30-minute checks. He was seen and assessed by psych nurse practitioner, and they increased his antipsychotic (Quetiapine) from 100 milligrams to 150 milligrams in the morning. R41 was on 30-minute checks. 3.Review of the facility's Initial Incident Report dated 02/23/26 provided by the Administrator, revealed that on 02/03/26 at 5:53 PM, R56 on the Memory Care unit went into R46's room and removed the blankets from his bed. R46 stated he was hit in the face. The nurse immediately separated and assessed the residents. Staff moved both residents back to their rooms and initiated hourly safety checks for both residents. R46 did not sustain any physical or mental harm. Review of R46's admission Record located in R46's EMR under the Profile tab revealed R46 was admitted to the facility on [DATE] with diagnoses of depression, anxiety, dementia without behavioral disturbances, PTSD, and insomnia. Review of R46's quarterly MDS with an ARD of 01/21/26 located in R46's EMR under the MDS tab revealed R46 was rarely or never understood. R46 required substantial to maximal assistance with activities of daily living. During the review period, R46 was noted to experience hallucinations, verbal behavioral symptoms directed toward others on one to three days, other behavioral symptoms not directed toward others on one to three days and wandering behaviors on one to three days. Review of R46's comprehensive care plan revised on 02/05/26 in the EMR under the Care Plan tab revealed R46 has behavior: cussing and verbally threatening staff, frustration toward staff and others, throws items at staff, refuses medications, aggression with new faces/staff, poor safety awareness. The care plan interventions were updated on 02/05/06 to include hourly safety checks. Review of the Hourly Safety Checks dated 02/05/26 through 03/12/26 provided by the Administrator revealed staff were monitoring R46's whereabouts hourly. Review of the Physical Aggression Received Report dated 02/03/26 revealed CNA10 went to R46's room and overheard the nurse talking and R56 saying that's mine. Upon entry, CNA10 witnessed R56 in R46's room standing by the sink still saying that's mine. CNA10 walked R56 off the unit to cool off. Further review revealed RN3 heard yelling while she was in another resident's room. When she came out into the hallway, she heard R56 yelling at R46 telling him to get out of here this is my house. Upon arrival to room, RN3 noted R46 sitting upright on the side of the bed. R56 was pulling the covers at the foot of the bed, yelling and telling R46 to get out. RN3 intervened letting R56 know that this was R46's room and assisted R56 out of the room. R46 stated get a gun and shoot him. He hit me in my face. Left eye noted slight puffiness, pupils equal, reactive, and round. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of R56's admission Record located in R56's EMR under the Profile tab revealed R56 was admitted to the facility on [DATE] with diagnoses of anxiety, major depressive disorder, dementia with other behavioral disturbances and agitation. Review of R56's admission MDS with an ARD of 11/06/25 in the EMR under the MDS tab revealed R56 had severe cognitive impairment as evidenced by a BIMS score of three out of 15. R56 did not display any behaviors during the review period. R56 required supervision or touching assistance with ambulation. Review of R56's comprehensive care plan last revised on 02/06/26 located in the EMR under the Care Plan tab revealed R56 exhibits the following behaviors: compulsiveness, repeating words, invading personal space of others, passive aggressiveness, yelling at staff, disruptive at senior center, demanding, false accusations, restlessness, physical aggression, and attempting to assist residents he believes are in need of help. The pertinent interventions directed staff to assist the resident to develop more appropriate methods of coping and interacting. Divert resident by giving them alternative objects or activity i.e., 1 to 1, activity, gave food and fluids. Familiarize resident with own belongings and surroundings. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. One-on-one structured activity or taken out for a walk when getting restless or anxious. The care plan was also updated to include hourly safety checks. Review of the Hourly Safety Checks dated 02/05/26 through 03/12/26, provided by the Administrator revealed staff were monitoring R56's whereabouts hourly. During an interview on 03/10/26 at 9:30 AM, R46 denied any abuse or that anyone came into his room and punched him. Attempts to interview CNA10 on 03/12/26 at 3:00 PM and CNA6 at 3:45 PM were unsuccessful. Messages were left for CNA10 and CNA6 to call back for an interview; however, they did not return the call prior to survey exit. During an interview on 03/12/26 at 3:06 PM, the NS/RN stated that R56 was transferred to the dementia/locked unit because of his cognitive decline. R56 likes to swear and R46 does not like that and gets upset. R56 entered R46's room and R46 stated he was hit in the face. Staff immediately intervened, separated, and assessed the residents. After the incident, staff placed R56 on hourly safety checks. During an interview on 03/12/26 at 4:30 PM, the Administrator stated that they are tracking resident to resident incidents, resident complaints, and all reportable incidents. The facility provides mandatory education when there is an allegation of abuse. For the residents on the dementia/locked unit, we have moved residents, implemented stop signs on resident doors to help prevent residents from wandering into other resident rooms, and initiated safety checks (i.e., hourly, every 30 minutes or every 15 minutes) based on the situation. Currently, the facility is looking into some deescalation training for staff. Additionally, the facility has increased staff on the dementia/locked unit so that a staff member is in the common area and can view both halls, and a staff member in the dining/TV area to monitor residents. Review of the facility's policy titled, Resident Abuse revised on 04/05/23, revealed, The Delaware Veterans Home (DVH) is committed to providing safe and respectful environments that support the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	health and well-being of all people receiving services. DVH seeks to institute guidelines and resources for staff and enforce zero tolerance for those actions which may jeopardize the health, safety or welfare of any person receiving services.

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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 observations, record reviews, interviews, and document review, the facility failed to prevent an accidents. Specifically, a resident fell from a Hoyer lift during a transfer for one out of three residents (Resident (R)51) reviewed for Hoyer lifts. This failure to prevent an accident which resulted in R51 experiencing actual harm of a skin tear to the resident's right elbow.Findings include:Review of R51's electronic medical record (EMR) Face sheet under the Admissions tab that R51 was admitted on [DATE]. Under the EMR section titled Medical Diagnosis tab had pertinent diagnosis including spinal stenosis, lumbosacral region, Alzheimer's disease, vascular dementia with other behavioral disturbance, bipolar disorder, pain, spinal stenosis, Review of R51's quarterly Minimum Data Set (MDS) in the EMR under the MDS tab with an Assessment Referent Date (ARD) of 08/13/25 with a Brief Interview for Mental Status (BIMS) score could not be conducted due to resident was rarely/never understood. Review of the MDS indicated that R51 was dependent on staff for transfers from bed to chair.Review of R51's Care Plans under the Care Plan tab in the EMR revealed an ADL self-care performance deficit r/t [related to] Dementia.is totally dependent on one staff to provide shower. and was dependent on Hoyer lift x2 [with two people assist] .Review of R51's Physician Orders dated 08/06/24 in the EMR under the Physician Orders tab revealed, Transfer: Hoyer lift.Review of R51's EMR review under the tab titled Progress Notes revealed a Health Status Note dated 08/12/25 at 5:46 PM revealed, resident s/p [status post] fall, while trying to get him back from the shower bed back to his wheelchair, the Hoyer lift tip [sic] over and he was lower [sic] to the floor by the CNAs [Certified Nursing Assistants] resident [R51] had a skin tear.Review of R51's EMR Progress Notes tab indicated an Incident Note dated 08/12/25 at 7:05 PM revealed, CNA came to me and stated [R51] was on the floor in his sling. The Hoyer lift was being used with the legs widened, to put the resident in his Geri-chair. As the resident was heading to the chair, the Hoyer tipped sideways. The CNAs held the sling on each side of the resident's head, preventing him from hitting anything and resident was lowered to the floor. His L [left] elbow had a 1.0 cm x 0.1cm [centimeter] skin tear Review of R51's EMR under the Progress Notes tab indicated a Post Fall Evaluation Fall dated 08/12/2025 at 4:20 PM, Fall was witnessed. Fall occurred in the bathroom. Activity at the time of fall: transferring via Hoyer with staff assistance of two. Reason for fall: Hoyer tipped sideways. Did an injury occur as a result of the fall: Yes. Injury details: 1.0 cm x 0.1cm skin tear on R [right] elbow. Did fall result in an ER [emergency room] visit/hospitalization: No. Fall Details Note: CNA stated this resident was on the floor in his sling. The Hoyer lift was being used with the legs widened, to put the resident in his Geri-chair. As the resident was heading to the chair, the Hoyer tipped sideways. The CNAs held the sling on each side of the resident's head, preventing him from hitting anything and resident was lowered to the floor. His L [left] elbow had a 1.0cm x 0.1cm skin tear. Review of R51's EMR Physician Order under the Orders tab revealed an order dated 08/13/25 that indicated, 2- view X-RAY to rt [right] humorous, rt hand and rt forearm.The facility's investigation revealed the Hoyer tipped to the side because CNA7 pushed the lift's feet apart instead of using the button. CNA6 and CNA8 lowered him to the ground. Statements from the CNAs involved revealed the same conclusion. Review of R51'sEMR under the Progress Notes tab revealed a note titled Lab Results dated 08/13/25 at 6:05 PM revealed, [R51] lab results hand [2 views] right, no gross fracture or dislocation, humerus [minimum of 2 views] Right no acute fracture or dislocation, Forearm [2 views] Right, no fracture or dislocation. review with team health provider with no new order. During an interview on 03/12/26 at 8:49 AM, Nursing Supervisor/Registered Nurse [NS/RN] stated that R51 was dependent with ADLs, used a Hoyer lift with two people assist to transfer. NS/RN stated that anyone who uses a Hoyer Lift or a sit to stand lift needed to have two people to operate the lift safely. The incident was two CNAs [CNA6 and CNA8] that lowered [R51] in the bathroom, to the floor and he had an elbow injury. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two CNAs who were involved had Hoyer lift reeducation. We evaluated their competencies and those two people had extra reeducation. They were agency staff who are still working with us but not working today. [R51] uses a recliner Geri chair.During an interview with CNA6 on 03/12/26 at 10:35 AM, showed the Joerns Hoyer Advanced 340 and stated it is less steady and the one they had an accident with. This lift the CNA had to manually push a foot pedal to open the legs. It is stored in the shower room and rarely used.During an interview on 03/12/26 at 1:56 PM, NS/RN stated, [R51] was using the manual mechanical lift at the time. We educated the staff as an intervention. There was no change in lift use. It was a witnessed fall. Staff were educated using mechanical lift. The CNAs observed the Hoyer tilting and lowered him to the floor. The straps were maybe more to one side than the other.During an interview on 03/12/26 at 2:11 PM, the Director of Nursing (DON) stated, I was doing my rounds and found out [R51] was having pain in his right arm because he fell out of the lift. He was getting a shower and when they were putting him back into the chair is when he fell. The CNAs were using the electric Hoyer lift. The two CNAs [CNA6 andCNA8] and [CNA7] were operating the machine. [CNA7] was on light duty and was not supposed to be using the Hoyer lift. [CNA7] was trying to get the legs open, and it did not open. She was trying to pull the legs out and it started tipping to the side. The other two CNAs [CNA6 and CNA8] lowered him to the floor so he would not have too much injury. He was grimacing and making a moaning noise for his right elbow movement. The facility did x-rays and they showed no broken bones. [CNA7] was not supposed to be using the lift anyway. Maintenance and the DON looked at it and there were no problems with the Hoyer lift. She [CNA7] no longer works here after this incident. We did competencies with all the staff, and they were able to demonstrate proper use of the Hoyer Lift.Review of the facility's undated document titled, Delaware Veterans Home Hoyer Lift Competency provided by the Administrator revealed that an evaluator would mark either pass or fail with a space for follow up needed. The Administrator stated that the facility had no specific policy and procedure for Hoyer Lifts, just this Competency document. The Procedure indicated, .Ensure two staff members are present when using the lift. 8. Position Hoyer Advance lift with legs open as far under the bed as possible (keep brakes off). Lower cradle to allow sling to be attached. 9. Attach both sides of the sling to their respective side of the cradle. Short straps at top, long straps at bottom to facilitate sitting position. 10. Utilizing the handheld control or the control panel, lift resident up until buttock is above mattress. Grasp residents' legs and turn so legs are off the bed. 11. Roll Hoyer Advance away from the bed. Position resident over desired location (chair, wheelchair). 12. Lower resident into place.