STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265352	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

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 - 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** 25073 Based on observation, interview and record review, the facility failed to ensure a resident's right to be safe during a transfer when a staff member transferred the resident without a using a Hoyer lift (a mechanical device to assist with transferring) and/or without additional staff assistance, and against the facility's policy, which resulted in the resident sustaining a fractured leg (Resident #20). The facility also failed to ensure all nursing staff had access to residents' electronic medical records through Point Click Care (PCC) prior to working with residents. This prevented staff from having access to care plans and/or Kardex (filing system used as a quick reference for staff) information. The facility failed to inservice staff and update care plans with the most current information regarding resident care needs. The facility also failed to prevent a cognitively impaired resident (Resident #19) from exiting through a secured door without staff knowledge and leaving the facility property. The resident walked 0.1 miles away from the facility towards a busy street. The facility failed to put additional interventions in place to ensure the resident's safety, and/or inservice all staff on the facility elopement policy so staff were able to identify residents at risk for elopement. The sample size was 14. The census was 52. Review of the facility's Total Mechanical Lift policy, revised: August 1, 2023, showed: Purpose: A mechanical lift is used appropriately to facilitate transfers of residents. Policy: I. Nursing Staff will be trained to use the mechanical lift; II. The resident will have a physician's order for the use of a mechanical lift; III. Resident will be transferred with a mechanical lift as per manufacturer's guidelines. IV. Nursing Staff will lock brakes according to the manufacturer's guidelines; -Procedure: I. Wash hands before and after each procedure; II. Explain procedure to resident and provide privacy; (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 - Actual harm Residents Affected - Few	Ill. Place lift sling under resident; A. The resident should be in center or one side of their bed; B. Roll the resident on the side away from staff; C. Roll the client towards the staff; D. Fold the sling in half lengthwise and place it next to the resident. The bottom end should be just above the resident's knees and the top end should be just above the armpits; E. Roll the resident onto his/her back and to the other side; F. Pull the remaining half of the sling from under the resident to unfold it so that it lays flat on the bed; G. Roll the resident onto his/her back, over the sling. Arrange the resident's arms so they are straight and flat next to the body.; IV. Position the lift under the bed or around the resident's chair as applicable. V. Set base legs to the widest position under resident. VI. Lower the boom bar. Lower it enough that the sling loops will reach the sling hooks, but not so low that it touches the resident; VII. Hook the loops on the sides of the u-sling to sling bar. Attach each corner of the sling to the correct hook on the sling bar; For slings with leg loops, cross the leg loops under the resident's legs and bring the end of the straps through the legs. Make sure the left loop is reaching across to hook to the right hook, while the right loop is reaching across to hook to the left hook, and that the hooks are set away from the boom of the lift apparatus. This crisscross helps the resident's legs stay together and keeps the user from slipping out of the sling; VIII. Raise the boom bar on the lift; IX. Keep resident centered between legs of the base and facing toward the person who is operating the mechanical lift. X. Move resident to destination. XI. Lower resident and position comfortably. XII. Narrow the base's legs and return the lift to the storage area; -The facility policy did not address how many staff were to be present during a total lift transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's Wandering & Elopement policy, revised: October 24, 2022, showed: -Purpose: To enhance the safety of residents of the Facility. -Policy: The Facility will identify residents at risk for elopement and minimize any possible injury as a result of elopement. -Procedure: I. The Licensed Nurse, in collaboration with the Interdisciplinary Team (IDT), will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition according to the RAI guidelines to determine their risk of wandering/elopement; II The resident's risk for elopement and preventative interventions will be documented in the resident's medical record, and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition according to the RAI guidelines; III. IDT may consider interventions for residents identified to be at risk for elopement; IV. Residents with a history of wandering or who IDT have assessed to be at risk for wandering or elopement will have a photograph maintained in their medical record; V. Facility Staff will reinforce proper procedures for leaving the Facility for residents assessed to be at risk of elopement; VI. If Facility Staff observes a resident leaving the premises without having followed proper procedures, he/she may: A. Try to prevent the departure in a courteous manner; B. Get help from other Facility Staff in the immediate vicinity, if necessary; C. Direct another Facility Staff member to inform the Charge Nurse or Director of Nursing Services that a resident is trying to leave the premises; Response to Resident Elopement A. The facility Staff member who finds that a resident is missing will alert facility Staff; B. The Charge Nurse will call CODE. _____ and organize a search. facility Staff will search areas of the facility, including common areas, bathrooms, showers, outside areas, etc; C. If the resident cannot be located, the Charge Nurse will notify: i. Administrator/designee; ii. Director of Nursing Services/designee; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	iii. Attending Physician; iv. Responsible Party; D. The Administrator/designee will contact local law enforcement and provide them with the following information: i. The resident's name, description (hair and eye color, complexion, weight, height, clothing, distinguishing marks, etc.), addresses and telephone number of resident's previous residence and family members; ii. The resident's mental status and pertinent medical conditions; iii. How to return the resident to the facility; A. The Administrator/designee will continue to work with law enforcement and the responsible party until the resident is located; F. The Licensed Nurse most familiar with the incident will document in the resident's medical record how the elopement occurred; G. The Facility will make necessary reports to state agencies; -VIII. Return of a Resident: A. When an individual who departed without following proper procedures returns to the Facility, the Director of Nursing Services or licensed Nurse should: i. Examine the resident for any possible injuries; ii. Notify the Attending Physician; iii. Notify the resident's responsible party. B. The Licensed Nurse will initiate or update the resident's Care Plan and implement and immediate intervention(s) to prevent further wandering/elopement by the resident; C. The IDT, with input from the Licensed Nurse, will conduct a thorough review of the elopement, document its findings in the IDT notes, and update the Care Plan to prevent a recurrence. D. The Quality Assessment & Assurance Committee will review all instances of elopement. 1. Review of Resident #20's medical record, showed his/her diagnoses included muscle weakness, contracture of left hand (deformity and rigidity of joints), muscle wasting (loss of muscle mass and strength), need for assistance with personal care, contractures of the left and right upper arm and traumatic brain injury (TBI-brain dysfunction caused by an outside force to the head). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's care plan, dated 9/11/23 and revised on 7/2/24 (two days after the resident was discharged from the facility), showed: -Focus: Resident has an Activities of Daily Living (ADL) self-care deficit related to TBI; Goal: Resident will maintain current level of function through the next review date; -Interventions: Resident is total assist with bed mobility, the Resident is a total assist for locomotion in manual wheelchair, bathing, bed mobility, dressing, personal hygiene, and toilet use. The resident requires a mechanical lift with (2) staff assistance. Review of the resident's care plan, dated 10/19/23, revised on 11/28/23, showed: -Focus: Resident is at risk for falls; -Goal: Resident will not sustain serious injury through the review date; -Interventions: -Anticipate and meet the resident's needs as needed; -Educate the resident and family/caregivers about safety reminders and what to do in case a fall happens; -Ensure the resident's call light is in reach and encourage resident to use it for assistance as needed; -Ensure the resident is wearing appropriate footwear when ambulating or mobilizing in a wheelchair, follow facility fall protocol. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 4/5/24, showed: -admitted to facility on 8/26/24; -Severely cognitively impaired; -No behaviors; -No refusal of care; -Impairment of upper and lower extremities; -Dependent for tub/shower transfer; -Dependent for chair/bed-to chair transfers; -Non-ambulatory; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-No musculoskeletal diagnosis including osteoporosis (thinning of the bones). Review of the resident's Physician's Order Sheets (POS) for June 2024, showed no order for a mechanical lift or any information about the resident's transfer status. Review of the resident's progress notes, dated 6/29/24, showed: -10:37 A.M., (late entry), staff placed a call to physician, awaiting return call; -11:33 A.M., (late entry), Certified Nursing Assistant (CNA) came to this writer and stated the resident complained of pain in his/her right knee after returning to bed after a shower. Family member at bedside. The writer assessed the resident and noted redness or swelling on right thigh and shin without discoloration. The resident said he/she was in pain when being repositioned and requested as needed (PRN) medication. Staff administered medication; -11:48 A.M., (late entry) staff notified the Director of Nursing (DON) and Administrator of resident's pain after transfer and orders for X-rays; -12:15 P.M., (late entry) the physician returned call, ok for x-ray of right hip, tibia (large bone on inner side of lower leg), fibula (bone on the outer side of the lower leg), femur (large bone in upper leg), knee and ankle; -2:57 P.M., (late entry) the resident resting comfortably in bed in no obvious distress. No bruising noted to right lower extremity (leg). No questions or concerns at this time; -10:50 P.M., results of X-ray showed acute fracture involving proximal tibial metaphysis (knee area). Staff reported findings to resident's physician. New order to send the resident to the hospital for evaluation and treatment. Staff called the DON to inform her. Review of the resident's radiology results, dated 6/29/24, showed: -PROCEDURE: X-ray tibia and fibula; -Findings: -There is decreased bony ossification (old bone breaks down faster than new bone can grow) of the lower extremity; -Acute fracture involving the proximal tibial metaphysis; -The ankle and knee joint spaces are grossly intact; -No evidence of osteomyelitis (bone infection); -Impression: -Acute proximal tibial fracture, mild osteopenia (thinning of bones). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's undated investigation provided to the surveyor on 7/3/24, showed: -Date of Incident: 6/29/2024; -Initial Investigation: -The resident resides at [NAME] Rehab and Healthcare; -He/She has the diagnoses of but not limited to traumatic subdural hemorrhage (brain bleeding), nontraumatic subdural hemorrhage (brain bleeding not caused by trauma), alcohol abuse, muscle wasting and atrophy, osteopenia, and contractures of upper extremities; -The resident was noted to have a right tibial fracture; -Initial Interventions: -Pain medication administered; -MD notified; -X-ray ordered; -Increased monitoring of the resident monitoring pain; -Staff interviews initiated; -Investigation: -The resident has been working with therapy since September 2023 with Physical Therapy (PT)/Occupational Therapy (OT) and in the last two months, he/she has progressed to standing, pivoting transfers, and using parallel bars with therapy staff; -Therapy has noted that family takes it upon themselves to stretch the resident and do range of motion with him/her; -They have also been noted to assist with transferring resident as well; -After his/her therapy sessions this past week (as of 6/24/24), the resident began to complain of knee fatigue and Bilateral Lower Extremities (BLE-lower legs) discomfort; -He/She has been bedbound for approximately a year and half to two years so some discomfort would be expected; -X-ray results showed the resident's right knee is showing arthritic changes of the knee with proximal tibial fracture; -Osteopenia also noted in the knee at this time; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Femur showed normal bony ossifications (soft tissue get hard); -Hip and knee joint spaces are grossly intact; -The right hip showed arthritic changes along with osteopenia. -The right ankle decreases in bony ossification, arthritic changes at the mortise (ankle) with spurring (bone spurs) at the medial (inner) and lateral (outside) malleolus (ankle); -The right tibia and fibula showed decreased bony ossification of the lower extremity; -Acute fracture involving the proximal tibial metaphysis (wide part of the bone); -Noted osteopenia; -Spoke with physician regarding the X-ray result; -Physician stated (no date, time or written evidence) since the resident has severe osteopenia, he felt this could have been a spontaneous fracture and even a slight trauma/bump could have caused a fracture; -On 6/29/24 (no time provided), resident had pain to the RLE after shower; -CNA/shower aide interviewed and stated that he/she transferred the resident from the shower chair to her bed using a gait belt (assistive safety device); -As the resident stood with assist, the resident stiffened his/her leg and locked his/her knees; -At that time no pain was stated from the resident; -Transfer was completed; -The resident was situated in bed, prior to CNA leaving; -The resident stated he/she was having knee pain; -The CNA reported the resident's complaint to the nurse; -The CNA told the nurse of the stiffening during the transfer but that the resident did not yell out or complain immediately of pain; -The nurse assessed the resident and provided him/her with pain medication; -The nurse observed and palpated the resident's leg, all color and size were normal; -When the nurse assessed the pain, the resident stated he/she was in pain, medication administered; -Call was placed to the MD to order x-ray as precaution; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Conclusion: We cannot conclude if the resident sustained the fracture during transfer with CNA or if it was a spontaneous fracture since he/she was recently noted to be working with therapy on stand/pivot transfers to include standing in the parallel bars; -The investigation did not include any additional witness statements from staff, other residents, any representative of skilled therapy services and/or any family members. Review of the resident's skilled PT notes dated 6/1/24 to 6/28/24, showed no documentation the PT therapist worked with the resident for stand and pivot transfers. During an interview on 7/8/21 at 10:28 A.M., PT S said: -The only time he/she did a stand to pivot transfer with the resident was months ago when the resident first started working with physical therapy; -The resident was unable to perform a stand to pivot transfer safely and the exercise was not attempted again; -No facility staff were present during the stand to pivot transfer; -The physical therapy department never told staff the resident was appropriate for a stand to pivot exercise and no staff were ever trained or educated on a stand to pivot transfer for the resident; -In his/her professional opinion, it would be very unsafe to transfer the resident using one person and a gait belt; -The resident was a mechanical lift; -Physical therapy had been working with the resident for upper body strengthening, sitting straight in his/her bed and/or wheelchair, passive low-load stretching to maximize range of motion (ROM); -The resident often complained of aches and pains; -During the last treatment session on 6/28/24, the resident did not vocalize complaints of pain in his/her right lower extremities; -Facility staff were never told the resident's transfer status was anything but a mechanical lift. During an interview on 7/8/24 at 10:19 A.M., OT T said: -OT had been working with the Resident for several months; -OT had been working with the resident for upper extremity strengthening; -OT did not determine how residents were transferred; -He/She never worked with the resident for a stand to pivot transfer; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/she knew the resident was a mechanical lift. Review of the resident's skilled OT notes dated 6/1/24 to 6/28/24, showed no documentation the OT therapist worked with the resident for stand to pivot transfers. During a telephone interview on 7/9/24 at 10:15 A.M., the resident's family member said: -The resident has been at the facility since September of last year; -The resident is not able to stand and bear weight; -No facility staff notified the family member of the incident that occurred on 6/23/24; -The resident's roommate called and told him/her what was going on; -He/She called and asked staff to have the DON return her call; -He/She was never notified the resident was complaining of pain after an inappropriate transfer, he/she was not notified the facility was getting X-rays; -The resident was a Hoyer lift and had been a Hoyer lift since admission; -The resident's family was in close contact with the facility's therapy department; -The family worked with the resident with some things like holding a cup or fork, sitting up straight and would help with ROM and stretching exercises; -The resident's family would offer to help staff when they were providing care; -The resident's family had not ever attempted to transfer the resident without staff; -The resident's family, including the resident's parent, nor siblings, had ever been educated to not assist the resident. Review of the resident's shower sheet, showed it was dated 6/29/24 at 10:15 A.M., and signed by CNA F and Registered Nurse (RN) S. Review of a handwritten statement, dated and signed on 6/29/24, (no time noted) by CNA F, showed he/she transferred the resident twice using a gait belt. The resident complained of knee pain immediately after the second transfer. CNA F went and told the nurse on duty. Review of the resident's Kardex, dated 7/2/24, showed the resident was a 2-person, mechanical lift transfer; During a telephone interview on 7/2/24 at 1:20 P.M., CNA F said: -He/She worked at the facility on 6/29/24 during the 7:00 A.M. to 7:00 P.M. shift as the shower aide; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She went over the rules, time clock, dress code, schedules, and the handbook; -The handbook was online and new staff were expected to log in and read the handbook; -All new nursing employees then went to the DON and Assistant Director of Nursing (ADON) for additional training specific to the nursing department; -The DON was the one who gave new nursing employees access to PCC; -CNA F was not provided access to PCC until the 6/30/24. One day after the incident. Review of an active employee report as 6/30/24, showed: -Check marks by each employee's name with no explanation of what the check marks meant; -An un-dated list of employees with access to PCC. Review of an in-service sign-in sheet dated, 6/30/24 (no times or duration of presentation listed), showed: -In-service provided by the DON: Description of presentation: Resident information on proper transfer is on the resident's Kardex and on the care plan in PCC. *Do not transfer a resident without knowing how they transfer; -The in-service sign in sheet had 25 nursing staff signatures with two staff signing the in-service sheet twice. During an interview on 7/2/24 at 5:47 A.M., the DON said she was at the facility early to in service on transfers. She did not provide any additional information. During an interview on 7/2/24 at 2:32 P.M., the DON and Administrator said: -CNA F did not have a password to access PCC; -During the course of their investigation, it was noted some nursing staff did not have access to PCC; -On 6/30/24, the DON did an audit and made sure all nursing employees were provided access to PCC; -The DON did not in-service staff on the use of Hoyer lifts on 6/29, 6/30, 7/1 or 7/2/24. She in-serviced staff where to look in the resident's record to identify their transfer status; -Resident care plans should address the resident's transfer status. Review of the active nursing employee list, dated 6/20/24, showed 22 active employees had not been in-serviced on where to find residents' transfer status as of 7/8/24. During an interview on 7/2/24 at 5:30 A.M., CNA E said: (continued on next page)

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	265352	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manchester Rehab and Healthcare Center	312 Solley Drive Ballwin, MO 63021

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She had worked for the facility for 9-10 months; -He/She had not received any recent in-service training regarding how to determine a resident's transfer status; -He/She just has to ask a co-worker, the nurse or the resident. During an interview on 7/2/23 at 9:25 A.M., Licensed Practical Nurse (LPN) G said: -The resident had always been a mechanical transfer; -There should always be two staff present for a mechanical lift transfer; -He/She did not work the day of the incident; -He/She was not aware of what training was provided to new staff in regard to resident transfers; -He/She thought all residents had a Kardex; -CNAs always ask the nurse about a resident's transfer status. During an interview on 7/3/24 at 7:48 A.M., LPN I said: -He/She knew the resident was a mechanical lift at all times; -He/She didn't know what information was provided to new staff during training; -He/She had never received training about the mechanical lifts specific to this facility; -There was not classroom training; -The DON spoke to him/her and asked if he/she knew where to find residents' transfer status; -He/She signed the in-service sign in sheet. During an interview on 7/3/24 at 7:59 A.M., CNA J said: -He/She had worked for the facility for about two months; -He/She knew the resident was always a mechanical lift; -He/She never received training about the mechanical lifts specific to this facility. During an interview on 7/3/24 at 8:26 A.M., CMT K said: -He/She knew the resident needed to be transferred with a mechanical lift; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She did not receive any education from the DON about where to find transfer information on residents; -He/She didn't know which staff had access to PCC and who did not have access. During an interview on 7/3/24 at 8:34 A.M., CNA L said: -He/She knew the resident used a mechanical lift for transfers; -He/She knew mechanical lifts required two people to be in the room; -He/She never received training about the mechanical lifts specific to this facility; -He/She worked the day the resident's leg was broken; -CNA F transferred the resident using a gait belt; -CNA F never asked him/her what the resident's transfer status was; -CNA F had not worked since the day of the incident. During an interview on 7/3/24 at 8:18 A.M., CNA M said: -He/She knew the resident was supposed to be a Hoyer lift at all times; -He/She heard the resident was transferred with a gait belt and fractured his/her leg; -He/She knew a mechanical lift required two staff to be present at all times; -He/She had not been in-serviced about mechanical lifts and/or how to find a resident's transfer status since the incident occurred. During an interview on 7/3/24 at 8:38 A.M., CNA O said: -He/She knew the resident's leg was broken during a one-person transfer; -The resident has always been a mechanical lift since the day he/she was admitted ; -He/She did not remember any in-services on how to use the facility's mechanical lifts; -It is known two staff should be in the room during a Hoyer lift transfer. During an interview on 7/3/24 at 8:44 A.M., CNA P said: -He/She knew two people should be in a room during a mechanical lift transfer; -He/She knew that the resident was sent to the hospital because another staff member transferred the resident only using a gait belt; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He/She had not been in-serviced or trained on the facility's mechanical lifts. During an interview on 7/3/24 at 9:23 A.M., LPN Q said: -He/She heard the resident sustained a fractured leg due to an inappropriate transfer; -He/She did not know what training was provided to CNA's prior to them being put on the floor. During an interview on 7/3/24 at 7:52 A.M., the resident's roommate said: -His/Her roommate was in the hospital; -On 6/29/24, an unknown CNA transferred his/her roommate from a shower chair into bed which caused the roommate to break his/her leg; -Staff always used a Hoyer lift when transferring the resident, except when it was shower day; -Most staff did not use the lift when they put the resident in the shower chair because the lift pad would get wet; -He/She never saw the resident's family members attempt to transfer the resident without assistance. During an interview on 7/3/24 at 1:28 P.M., with the DON, Administrator and two corporate nurses; -The Administrator said the resident's roommate was alert and oriented to person, place, time and situation; -When told what the roommate said, the DON said the roommate had schizophrenia (mental illness that affects a person's ability to think, feel and behave clearly) and just liked to stir the pot; -His/Her statement was not to be trusted; -The DON called the resident's responsible party and notified him/her of the resident's X-ray results. During an interview of 7/8/24 at 11:49 A,M., the DON and Administrator said all inservicing had been completed regarding staff having PCC access and how to locate a resident's transfer information in PCC. During a telephone interview on 7/8/24 at 4:05 P.M., the resident's primary care physician said: -He was notified by staff the resident was complaining of right leg pain; -Staff did not provide any other details except to say the resident's leg was bumped; -He ordered X-rays of the resident's right leg including hip, pelvis, knee, and ankle; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-He was not at the facility and did not assess the resident prior to ordering the X-rays; -He only knew what the staff reported to him; -He was not told the resident started complaining of pain after a transfer; -When the facility notified him the resident's X-rays were positive for a fracture, he had the facility transport the resident to the hospital for evaluation and treatment; -He said any person with severe osteopenia was at higher risk for fractures including spontaneous fractures. Some residents with severe osteopenia could sustain a fracture from an incident as small as bumping their leg or repositioning them. He was not specifically speaking about the resident; -If the facility's policy shows physician's orders are required for the use of Hoyer lifts, the facility should make sure the order was obtained from him or any other physician who had residents in that facility; -If a resident had an order for a mechanical lift, a mechanical lift should be used at all [NAME]