

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 7023					Date: July 29, 2019
Facility Name: Parkridge Specialty Care		Survey Dates: July 17 - 18, 2019			
Facility Address/City/State/Zip 5800 NE 12 th Ave Pleasant Hill, Iowa 50327		MW/DC			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date	

58.28(3)e	58.28(3) Resident safety. e. Each resident shall receive adequate supervision to protect against hazards from self, others, or elements in the environment. (I, II, III) DESCRIPTION: Based on manufacturer's guidelines, clinical record review, staff interview, witness interview, observation, and facility record review the facility failed to ensure the straps of a sling for a mechanical lift securely attached to the machine prior to transferring a resident who subsequently fell from the sling during a transfer, for 1 out of 4 residents reviewed for transfer technique with a mechanical lift, (Resident #1). Resident # 1 sustained a non-displaced peri-prosthetic (around a prosthetic) femur fracture and parietal scalp hematoma (swelling). The facility identified the failure and corrected it on 7/2/19 when they retrained staff on the proper transfer technique for hoyer lifts. The facility reported a census of 80 residents. Findings include: 1. The EZ Way Smart Lift Operator's Instructions revised 6/13/11 included the following instructions	I	\$7250	Upon Receipt
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	on how to transfer a patient from a chair, wheelchair, or toilet with a full body mechanical lift (hoyer lift): Step 1. Position the Sling a. Lean the patient forward several inches to place the sling behind the patient. b. Make sure the base of the sling touches the chair seat and is 2 inches below the tailbone. Make sure the top of the sling above the patient's shoulders and lean the patient back in the chair. c. Pull the legs of the sling along the inside of the chair. d. To set the sling properly, you must do the following: On the patient's right side, position your right hand between the patient's hip and the sling. With your fingers, push down on the edge of the sling so it touches the base of the chair seat. Next, grasp the bottom edge of the sling leg with your left hand and pull with a tug towards you. e. Lift the patient's left knee and with a tug, pull the leg of the sling under the hip and thigh. Place the excess sling length over the left thigh. Repeat this procedure on the right side. Step 2. Position the EZ Way Smart Lift Step 3. Attach sling to the lift. a. Take the sling leg that is lying over the patient's left thigh and attach it to the right hook on the hanger bar.			
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	b. Take the sling leg lying over the right thigh and attach to the left hook on the hanger bar, again using the same length and color of loop strap on each side. c. Attach the straps located near the patient's shoulders to the lift hanger bar hooks using the same length and color of loop strap on each side. Example: If you choose the shortest loop on the strap for the right shoulder, you must use the shortest loop on the strap for the left shoulder. Step 4. Lifting the patient. a. Push the UP button on the hand control to initiate the upward motion of the lift. Continue the upward motion until there is tension on the legs of the sling, making sure all the loops on the sling are securely hooked on the hanger bars. b. Smooth the sling legs under the patient's thighs with a slight pull on the outside seam of the sling legs, if necessary. c. Lift the patient to the desired height (usually 2 to 3 inches above the chair). Step 5. Transferring the patient. a. Ensure there are no obstructions in the path of travel. b. Pull or push the lift using the operator's handles on the lift mast. Maneuver the lift to a desired location. Step 6. Lower the patient onto the bed. Step 7. Remove the sling.			
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	The facility Nursing Meeting Agenda dated 9/6/17 included the following documentation for Review of Lifts: a. No double looping of slings. b. Pause before lifting up to double check the resident's position. c. Do not lock brakes during lifting. d. Continue to bring ripped slings for replacement. Staff B, Certified Nurse Aide (CNA), signed attendance to the meeting. The facility list dated 7/17/19 identified 13 current residents utilized a hoyer lift for transfers. 2. The Minimum Data Set (MDS) assessment dated 6/7/19 for Resident #1 identified a Brief Interview for Mental Status Score (BIMS) of 8 indicating moderate cognitive impairment. The resident was totally dependent upon two persons for transfers. Resident #1 had diagnoses of Cerebrovascular Accident (CVA), Hemiplegia (weakness on 1 side of the body) and general muscle weakness. The Care Plan focus area dated 5/25/18, identified Resident #1 was a risk for falls. On 4/25/19 the Care Plan was revised to inform staff			
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	the resident transferred with a hooyer lift and the assistance of two persons. The Witnessed Fall Report dated 7/1/19 at 9:05 p.m. completed by Staff C, Registered Nurse (RN) indicated she was called to Resident #1's room by a CNA who reported the resident fell to the floor during a hooyer transfer landing on her left side. Staff C recorded she arrived in the room to find the resident on her left side with head on pillow and a swollen bump on the back of the left side of head. Staff C recorded when the resident rolled onto her back the resident yelled out in pain stating her right hip and leg hurt. A hooyer transfer was completed with extra staff to keep the right leg to minimal movement as they moved the resident back to the bed. The report documented the witnesses were Staff A, CNA, and Staff B, CNA. The Progress Notes dated 7/1/19 at 10:17 p.m. documented Resident #1 fell to the floor during a hooyer transfer hitting her head on floor. The resident had a raised, tender area on the back left side of head. The on-call physician was contacted and an order received to send the resident to the Emergency Room for further evaluation. At 10:57 p.m. the notes recorded after the incident the sling was checked over with no tears or fraying found and the correct size			
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	sling was used for the transfer. The entry documented a visitor had been in the room at the time of the transfer and had witnessed the fall. The radiology report completed 7/1/19 at 11:05 p.m. documented findings of a proximal (toward the beginning) right femoral shaft fracture extending to the prosthetic caudad margin (toward the tail or posterior end). The hospital H&P (History & Physical) dated 7/2/19 at 9:46 a.m. documented the resident presented to the hospital after a fall from a hoier lift and x-rays showed a right hip non-displaced peri-prosthetic (around artificial replacement part) femur fracture. The record documented while in the ED (Emergency Department) a head CT (computed tomography) scan showed a parietal (side) scalp hematoma (localized swelling). The Assessment section documented the resident had a very extensive medical history and was a very poor operative candidate. The fracture was non-displaced and therefore non-operative care was the reasonable course of action. On 7/3/19 at 12:56 p.m. the Progress Notes documented Resident #1 was readmitted to the facility after hospitalized with a right femur fracture.			
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	The undated witness statement written by Staff A documented the following: During HS (bedtime) cares, Resident #1 was being transferred into bed with a hoier and the hoier sling slipped out. Staff A's hall partner was busy so he asked Staff B for assistance. During the time that it took Staff B to come in, Staff A brought the hoier (machine) into the room and hooked Resident #1 up (connected the sling straps to the machine). Staff A always slid in the sling straps all the way into the hooks before they got the resident up just as he did that day. Once Staff B came in the room, Staff A got behind the wheelchair and he always double checked the straps to make sure they were on correctly, which they were. As Staff B lifted Resident #1 up, Staff A started to pull away the wheelchair to make room for the hoier to move and that's when it appeared as if one of the straps snapped and the resident fell. After the resident fell, Staff A checked the straps to see if it tore or ripped but it appeared to be fine. The sling was the right size and they were not rushing anything so still unsure as to how it came off. The Director of Nursing (DON) wrote a summary of her interview with Staff A. The DON documented the interview occurred on 7/2/19 at 4:30 p.m. During the interview, the DON had Staff A re-enact the hoier transfer with the Administrator and her. The DON wrote: Staff A			
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	stated while he waited for Staff B to come to the room, he proceeded to hook up the hoyer sling to the lift. Staff A stated the sling already underneath the resident where she sat in a wheelchair. Staff A stated as he was hooking up the straps he paid attention to each strap and remembered they were all in good condition. During the re-enactment, Staff A placed the straps into the cross members of the lift and noted he double looped the straps. Re-education provided regarding the manufactures recommendation to refrain from double looping the straps. Staff A confirmed he double looped the straps on the evening of the transfer in question. Staff A proceeded to attach each strap to the cross members, starting at the top left, then going to the bottom left, then to the bottom right and finally ending with the top right. Staff A stated by that point, Staff B entered the room and they proceeded with the transfer. Staff A went behind the wheelchair while Staff B proceeded to raise the resident with the lift. Staff A stated as the resident raised off of the wheelchair enough for him to remove the chair, he moved the wheelchair behind him enough so the hoyer could be moved towards the bed. Staff A then said just as he moved the wheelchair, the resident jerked in the sling and fell out of the top left side of the sling onto the floor. Staff A stated he was still unsure as to how the resident fell out of the sling,			
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	because he checked the sling for any rips, tears, or frayed areas after the incident occurred and the sling was in good working condition. During the re-enactment scenario, they found that if the loop of the strap was on top of the cross member bar, they could lift the individual out of the chair. Once the individual moved slightly, the loop of the strap then slipped off of the cross member bar causing the sling to slip off. After completion of the return demonstration and their re-enactment of their plausible explanation, they concluded the sling strap was just above the cross member of the hoyer device instead of inside the cross member. The witness statement written by Staff B, signed 7/1/19, documented the following: Staff A asked her for transfer help so Staff B went to help him. Resident #1 was already hooked up with the sling and hoyer. Staff B started going up with the hoyer and it looked like the back strap had broke. After the resident fell, they looked at the straps and it wasn't broken. The DON wrote a summary of her interview with Staff B. The DON documented the interview occurred on 7/2/19 at 4:30 p.m. During the interview, the DON had Staff B re-enact the hoyer transfer with the Administrator and her. The DON wrote: Staff B stated Staff A asked her for help			
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	with a transfer because his hall partner was busy. Staff B finished up what she was doing then went into Resident #1's room to help Staff A. Staff B stated when she got into the room, Resident #1 was already hooked up to the hooyer and the sling already in place. Staff B recalled everything looked normal as far as the sling and the resident placement. Staff B stated she then proceeded to raise the hooyer up with the button, as the resident's bottom lifted off the wheelchair enough to allow the chair to be moved, Staff A moved the chair out of the way. Staff B said as soon as the wheelchair moved, the resident jerked in the sling and fell out of the upper left portion of the sling onto the floor. Staff B stated at first it appeared as if the strap broke, but after the fall they checked the strap and it was not broken. Staff B recalled the sling and all the straps were in good working condition and she did not remember seeing any rips, tears or frayed areas present. Staff B stated she was still unsure as to how the resident fell out of the sling. During the re-enactment scenario, they found that if the loop of the strap was on top of the cross member bar, they could lift the individual out of the chair. Once the individual moved slightly, the loop of the strap then slipped off of the cross member bar causing the sling to slip off. After completion of the return demonstration and their re-enactment of their plausible explanation, they concluded the sling			
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	strap was just above the cross member of they hoyer device instead of inside the cross member. The DON wrote a summary of her phone interview with Staff C, RN. The DON documented the interview occurred on 7/8/19 at 10:00 a.m. The DON wrote: Staff C stated on the evening of 7/1/19 at approximately 9:00 p.m., she was called to Resident #1's room by one of the CNAs; the aide told her the resident had fallen from the hoyer. Staff C was unable to recall if Staff A or Staff B called her to the room. Upon entering the resident room, Staff C noted the resident laid on the floor on her left side, a pillow underneath her head. Staff A and Staff B were the CNA's transferring the resident by use of the hoyer lift from the wheelchair to the bed. Staff A and Staff B stated to Staff C the resident had fallen out of the left side of the hoyer sling during the transfer. During Staff C's initial nursing assessment, the resident complained of right hip and leg pain. Staff C said as she finished her assessment, the resident stated her pain was better in her right hip then said, it hurt like it always did. Staff C stated after she completed her nursing assessment, she immediately checked the hoyer sling for any defects. Staff C recalled not finding anything wrong with the sling; no rips, tears, or frayed areas present. Staff C proceeded to inspect the hoyer device itself for			
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	any malfunction, found the lift to be in good working order, then assisted Staff A and Staff B to replace the sling underneath the resident. The three of them proceeded to transfer the resident off of the floor and into the bed with the use of the hoier. Staff A and Staff B transferred the resident and Staff C provided additional support of the resident's right leg. Staff C stated she then began neurological assessments and placed a call to the physician. An order was received from the physician to send the resident to the Emergency Room for evaluation and treatment. Staff C said the resident's visitor had been present in the room during the transfer. Staff C spoke with the visitor privately and asked if there were any concerns with the transfer prior to the incident occurring. The visitor told Staff C they had no issues with anything they did and they did everything like they usually did. Staff C was unsure how the incident occurred and felt as though it was a fluke occurrence. The Corrective Action Form, signed by Staff B on 7/15/19, documented on 7/1/19 Staff B completed a hoier transfer with a resident who experienced a fall from the hoier lift. The hoier device and the sling used in the transfer had been inspected and found to be in good working order. The fall appeared to have resulted from the lack of ensuring the straps hooked to the lift properly.			
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	The Corrective Action Form, signed by Staff A 7/16/19, documented on 7/1/19 Staff A completed a hoyer transfer with a resident who experienced a fall from the hoyer lift. The hoyer device and the sling used in the transfer had been inspected and found to be in good working order. The fall appeared to have resulted from the lack of ensuring the straps hooked to the lift properly. During interview on 7/17/19 at 11:30 a.m., the DON reported Resident #1's health was declining prior to the fall and after the fall the resident returned to the facility on hospice level of care. The DON said the resident now bed bound for comfort measures and would not be getting out of bed during the survey process. The DON commented discussion regarding hospice level of care had occurred prior to the resident falling between the physician, the family, and her. The DON said the resident was diagnosed with a non-displaced fracture and no surgery completed; resident's treatment consisted of comfort measures. The DON stated the resident had chronic hip pain, worsened since the fall, but currently under control with orders for morphine and something for breakthrough pain.			
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	Observation on 7/17/19 at 1:09 p.m. revealed Staff D, CNA, and Staff E, CNA, entered the resident's room to provide repositioning. Resident #1 moaned when the pillows used for positioning were removed. The pillows were behind the right hip and under her calves. Resident #1 was able to say which way she wanted to turn. The resident was turned to the left side and the resident called out in pain. The DON stated the resident did not recall the fall. Once Resident #1 was not being moved she appeared to be comfortable and voiced she felt okay and what pillows she wanted. On 7/17/19 at 2:10 p.m. Staff C, RN, recalled working the 2 p.m. to 10 p.m. shift the night Resident #1 fell on 7/1/19. Staff C stated either Staff A or Staff B came to get her saying Resident #1 fell out of the hoyer. Staff C reported the resident laid on the floor angled in front of the bed with feet towards the wall and head towards the bed on her left side. Staff C stated a bump was present on the left side of the resident's head towards the back and the resident reported her right leg hurt. Staff C said the aides only moved the resident's head to place a pillow under it. Staff C commented she wasn't concerned as much about the right leg because the resident laid on the left side. Staff C commented both she and the EMTs (Emergency Medical Technicians)			
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	asked the resident if the right hip pain was more than her normal chronic pain and the resident said no. Staff C stated she worried more about the resident's head but neurologically the resident her normal self. Staff C said after assessing the resident, they laid her back down in bed with the use of the hooyer. Staff C reported because the resident's leg sore, Staff C held the leg during the transfer. Staff C stated she looked at the sling as both aides said at the moment it happened they thought the strap broke over her left shoulder but further inspection revealed no rips or tears with all loops intact; same sling used to put the resident back into bed. Staff C reported she asked the aides if the usual size sling used for the resident and they said yes. Staff C commented again the aides said it looked like something broke loose from the machine. Staff C stated a visitor present in the room, she asked if they had concerns, and they did not. During interview on 7/17/19 at 2:30 p.m., Staff B reported she worked for the facility for 2 to 3 years and recalled being present the night Resident #1 fell from the hooyer. Staff B stated Staff A asked for help, she thought she was going to be a minute, so Staff A already connected the sling before she entered. Staff B said when she entered she started pushing the resident up with the controls, Staff A moved the chair back, then			
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	Staff B moved the hooyer back towards the bed when it looked like it broke at the left shoulder. Staff B stated the resident fell out hitting her head on the floor. Staff B said the resident's right foot tangled not up far from the ground no more than approximately 2 feet, left leg on the ground, and hips on the ground. Staff B said the right leg was on top of the sling so she lifted up the leg to get it off then put on the ground. Staff B stated she lowered the lift to untangle the sling, all 3 of the other hooks were still connected. Staff B reported she thought the black loop used on the shoulders (top), green loops used on the bottom, the other loops that weren't used double looped over the bar. Staff B stated Resident #1 made a groaning sound and she could tell the resident was in pain. Staff B then went to get Staff C to check her over. Staff B stated they then transferred the resident back into bed with the hooyer and with the same sling. They had looked it over and nothing was wrong with either the sling or the machine. Staff B responded she guessed the fall occurred due to the loop not in the hook all the way. It must have been on top or something or the weight balance wrong. Staff B reported when she entered the room it looked like everything was ready to go, she just glanced at it (the sling connection), then raised up the resident. Staff B stated the resident raised up okay, just when moved the machine back, the sling came off. Staff B believed at that			
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	moment Staff A had his hands on the resident's back. Staff B acknowledged the resident's visitor present in the recliner in the room at the time of the transfer. Staff B responded she felt trained on hoyers and knows if the right size sling used if a sling lined up to a resident's shoulders and below the tailbone. Staff B responded since the incident she watched a video, completed a quiz, and completed a demonstration of a transfer. During interview on 7/17/19 at 5:44 p.m., Staff A reported he worked for the facility for 3 and half years. Staff A recalled the night the resident fell from the hoyer. Staff A stated his hall partner was busy so he asked Staff B to help him. Staff A said when he asked for help it looked like Staff B could not come right away so he decided to get the straps hooked up to the hoyer. Staff B stated at that point he was behind the resident when Staff B entered and started to put the hoyer up. Staff A said he moved the chair, the hoyer was pretty high up, a loop came undone and the resident fell. Staff A recalled the loop that came undone was the very same loop he put in (connected) first. Staff A commented he had to reenact the whole scenario with the DON and the Administrator and he had never seen anything like that happen before. Staff A stated the sling looked like the average sling they used and he believed the sling the right size because it			
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Facility Administrator

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	matched up to the shoulders and the bottom part to the tailbone. Staff A recalled the color loops used to be how trained, always use the black loops on the top and the green loops on the bottom; top meaning by the shoulders. Staff A reported the resident did not slide or anything and he did not recall the resident being restless or moving. Staff A stated he pulled the chair away, a couple seconds passed, going to move to the bed, then the left shoulder loop came out and the resident fell. Staff A recalled his witness statement writing he double looped the connection. Staff A responded he was trained originally when he became a CNA for safety double loop so if a loop tore there would be another loop there. Staff A recalled the loops already in place and he moved to get around the wheelchair to stand behind to pull the wheelchair back when Staff B entered. Staff A reported Staff B grabbed he controls as the resident already set up to transfer. Staff A stated it looked like the resident's left shoulder side hit first, it was a fast fall, saw very quick, and then the resident was on the floor. Staff A reported the resident's lower half on the floor but her right leg still hung onto the sling as it went behind the knee. Staff A commented all 3 other loops were still connected to the bar. While Staff B went to go get help, Staff A moved the hoyer away and put a pillow under the resident's head. Staff A stated the			
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	nurse arrived to complete an assessment. Then they got the resident up with the hoier and back to the bed with the same sling. Staff A responded he had to re-enact the scenario and the DON said he left the loop on top but he knew to put it all the way in the hook. Staff A thought the loop was the first one he put on because of where the chair had been positioned it was always the closest one and the he would go around. Staff A thought maybe the loop came loose then as he put the other loops on. Staff A commented he was shocked as how got that high before coming loose. Staff A recalled receiving training prior to the fall incident via a video in orientation then trained on the floor during the first week of training. During interview on 7/17/19 at 6:05 p.m., the resident's visitor who witnessed the fall responded they hadn't been paying attention to the connection. The visitor thought they hooked it up then Staff A left the room, came back, and thought maybe staff did not check everything. The visitor stated one of the loops may have come off. The visitor said the resident went up fine, next thing they knew the resident going down. The visitor reported the resident fell almost 4 feet. The visitor reported they had observed the staff help before and the transfers were fine.			
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	During interview on 7/17/19 at 5:07 p.m., the DON stated they tell staff in training to use the black loops on top and green loops on bottom when connecting a sling to the hoist machine. The DON commented in the lift video used for training it talked about using those loops as it put a resident in a sitting position. On 7/17/19 at 5:20 p.m., Staff F, CNA, reported she worked for the facility since May 2018. Staff F responded the size sling to use for each resident was located on the kardex and she looked at the body size to tell if the sling comfortable for them. Staff F stated she was trained on the loops to use black loops for the top, shoulders, and green loops for bottom, legs; single loops not double. On 7/17/19 at 5:22 p.m., Staff G, Certified Medication Aide (CMA), responded she worked for the facility for 4 years. Staff G responded she knew which sling to use based on a list behind the supply room door and if not there she went to ask the nurse. Staff G said sling size was also on the iPad and responded the sling should be lined up from the shoulders to the tailbone. Staff G stated she used the green loops on legs and black loops for the top of the shoulders.			
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	On 7/17/19 at 5:26 p.m., Staff H, Licensed Practical Nurse (LPN), responded staff knew sling size to use by the kardex and the iPad listed size/color as well. The slings are marked with names and back ups were available. Staff H responded the sling should line up to the body with shoulders and the tailbone. Staff H stated the loops used depended on what transfer staff doing, bed or wheelchair and always a single loop to be used. On 7/17/19 at 5:28 p.m., Staff I, RN/Unit Manager, responded she worked for the facility since February 2019. Staff I stated staff choose a sling by the sign in the supply room, the slings were labeled. There was a video training that all staff had to watch and then take a test. Staff I stated the sling should line up thru shoulders down around the bottom, centered equally. The loops used were dictated in the video and in chart and depended on the positioning staff wanted, if wanted to lay down or sit up. Staff I felt she had training before the incident. On 7/17/19 at 5:33 p.m.. Staff J, CNA, responded she worked for the facility for 4 years. Staff J stated the sling size varied by the person and staff needed to put the sling on to see if too wide or not. Staff J stated the sling should line up by the shoulders and down to the tailbone. Staff J			
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	responded the loops used were seen in video and in training, you put the black loops first on the top and the bottom the green loops. On 7/17/19 at 5:35 p.m., Staff K, CNA, responded she worked for the facility for a year and a half. Staff K stated she knew a sling was correct based on labeled and color. Staff K stated the sling was supposed to line up to the shoulders and the tailbone. Staff K stated she decided the loops by black for the shoulders and green for the legs except if on the floor then needed to use the longest loops. Staff K commented she did the computer program training when first started and watched the videos on transfers. Staff K stated since the fall happened, she did an example with a nurse and watched the video again. On 7/17/19 at 5:38 p.m., Staff L, CMA, responded she worked for the facility for 3 years. Staff L stated she knew the sling size to use by asking the nurse or by measuring from the shoulders to the tailbone and to make sure not too loose or tight around the resident. Staff L responded she chose loop by 1 black loop on the top and 1 green loop on the bottom and criss cross. Staff L commented if she needed to fully lay down a resident she would do green and green but must take into consideration their body size.			
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	Plan of Correction On 7/18/19 at 10:30 a.m., the DON reported the staff watched a video from EZ way and then staff took the quiz and signed off completion. After the 12 question quiz, the DON checked to see if staff had questions and discussed if unsure of the answers. A competency audit was performed where the staff physically got an employee up out of the bed and into the chair. The DON reported they did this training process for all nursing staff including the Administrator, DON, and all management nurses. The DON said the trainings started on 7/2/19 and Staff A and Staff B retrained immediately, first. On 7/18/19 at 11:35 a.m., the DON reported Staff C retrained on 7/11/19 as Staff C went on vacation on 7/2/19. The DON stated the facility planned to train PRN (as needed) staff as they were scheduled. The DON stated after the incident she did not allow any employee to work until they were retrained. The facility corrected the above non-compliance on 7/2/19 by completing the following actions: Immediate Corrective Action - a. On 7/2/19 all mechanical lifts and slings were checked by maintenance for any defects. No defects found with any of the lifts or slings.			
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	b. On 7/2/19 re-education provided to all current nursing staff members on hoyer lift safety. Staff members watched a 20 minute video regarding proper usage of the hoyer lift device, they took a 12 question quiz after the videos, and then each staff member performed a hoyer lift transfer and the DON completed a transfer audit on each person. c. On 7/2/19, both the DON and the Administrator completed a re-enactment of the transfer with both of the CNA's involved in the incident. Ongoing Corrective Actions - a. Continuation of the monthly safety checks on all mechanical lifts and slings. b. Periodic transfer audits of staff members. On 7/10/19 the DON documented Additional Ongoing Corrective Action: Prior to the incident occurring with Resident #1 on 7/2/19, the facility shared hoyer slings among all the residents. On 7/8/19 the facility placed an order to allow 2 hoyer slings to be dedicated to each resident. The shipment expected to arrive 7/12/19. Upon arrival, each sling would be labeled with the residents name and would stay in each resident's room for that specific resident use only. One sling would be used and the other sling would remain in the resident room to be available when needed.			
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	FACILITY RESPONSE:			
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