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| NORTHERN MAHASKA SPECIALTY CARE | 2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577 |

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| F 000 ✓ Ok/CP | INITIAL COMMENTS<br><br>Correction Date 5/11/2023.<br><br>A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on May 3, 2023 to May 10, 2023. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.<br><br>The following deficiencies resulted from investigation of Complaints #107873-C, #112649-C, and Facility Reported Incident #112488-I conducted May 3, 2023 to May 10, 2023.<br><br>Complaints #112649-C and 17873-C were substantiated.<br>Facility Reported Incident #112488-I was substantiated.<br><br>See code of Federal Regulations (42 CFR), Part 483, Subpart B-C. | F 000 | "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Northern Mahaska Specialty Care does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced | F 689 | F689 Free of Accident Hazards/Supervision/Devices<br><br>Northern Mahaska Specialty Care residents have the right to an environment free of accident hazards as possible and receives adequate supervision and assistance devices to prevent accidents.<br><br>Resident #2 discharged from facility. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaitlyn Lewis — TITLE: Administrator — (X6) DATE: 6/12/2023

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| F 689 | Continued From page 1<br>by:<br>Based on observations, interviews and record review, the facility failed to ensure safety for 1 out of 3 residents reviewed (Resident #2). Resident #2 was transferred from her bed into her wheelchair without removing/moving the leg rests/foot pedals from Resident #2's wheelchair. This resulted in a large skin tear, which required the need to transfer Resident #2 out to the Emergency Room (ER). The facility reported a census of 68 residents.<br><br>Findings include:<br><br>A Minimum Data Set dated 3/9/23, documented that diagnoses for Resident #2 included heart failure, diabetes, and malnutrition. This resident's Brief Interview for Mental Status revealed a score of 14 out of 15, which indicated intact cognition. This resident was an extensive assist of 2 for bed mobility, and transfers.<br><br>A Medical Diagnoses list for this resident printed on 5/9/23, documented diagnoses of lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that's usually drained through the body's lymphatic system. It most commonly affects the arms or legs).<br><br>A Care Plan with a focus area initiated on 3/3/23 and revised on 5/7/23, documented that Resident #2 was at risk for skin breakdown due to diabetes, incontinence, and fragile skin due to lymphedema and hart failure. It documented that resident had edema to her bilateral lower extremities. It documented that this resident was re-admitted from the hospital with a left shin laceration. | F 689 | Staff including agency staff have been educated on appropriate transfer technique.<br><br>Director of nursing and/or designee will monitor transfer audits.<br><br>Transfer audits will be completed 5 times a week x6 weeks and then random audits thereafter.<br><br>Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated. | |

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A resident Census page documented that this resident went to the Emergency Room on 3/29/23.

A Progress Note dated 3/29/23 at 3:25 p.m., documented that this nurse was called to the resident's room STAT (immediately). Resident was observed sitting up in her wheelchair with a large skin tear to her inner leg. Area was cleaned with wound wash and steri strips were applied. Moist dressing was also applied and wound was covered with gauze. The provider was notified and a new order was received to send this resident to the ER to evaluate and treat wound. Daughter was agreeable to hold this resident's bed while out of the facility. The DON (Director of Nursing) and ADON (Assistant Director of Nursing) were at bedside. The Certified Nurse Aides explained that resident was being assisted to her wheelchair with the Hoyer lift and while bringing the resident down into her wheelchair, her left leg slipped off the wheelchair pedal, so it was moved causing a skin tear.

A Progress Note on 3/29/23 at 3:35 p.m., documented the skin tear measured Length 6.9 centimeters (cm), Width 4.6 cm, and the Depth was 1.5 cm. This resident was sent to the ER for bleeding and pain.

A Progress Note dated 3/29/23 at 4:44 p.m., documented that in a phone call with Resident #2's daughter to let daughter know about the skin tear, the daughter stated she wasn't surprised as her mom's skin is very fragile.

A Progress Note dated 3/29/23 at 8:00 p.m., documented that this resident returned from the ER. A new order was received to moisten gauze,

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cover (wound) with dry gauze, watch for signs of infection, and protect area from further trauma.

A Skin and Wound Evaluation dated 3/31/23, documented that a skin tear on the left shin had complete tissue loss and the wound was acquired at the facility on 3/29/23. The length of the wound was 10.3 cm and the width was 10.6 cm with no depth. The edges of the wound were not attached and appeared as a cliff. The surrounding tissue was black and blue, intact and fragile. This resident had edema extending more than 4 centimeters around the wound. It documented that this resident had occasional labored breathing with a short period of hyperventilation, occasional moan or groan, facial grimacing and that this resident rated her pain at a 5 out of 10 (which indicated moderate pain).

On 5/9/23 at 11:40 a.m., Staff A, CNA, stated on the day of this incident she was going over to talk to a staff member about something, when she walked into this resident's room they were transferring Resident #2 to her wheelchair. When Staff A walked into the room she noticed that Resident #2's leg was on the wrong side of her wheelchair pedal, which the leg rest should not have been on (the wheelchair) in the first place. The leg was on the left side of Resident #2's foot pedal, so Staff A believed it would have been her left leg. Staff A stated the middle of this resident's lower leg caught on the foot pedal, it was like the calf area. Staff A stated when that happened it opened up the skin and it started bleeding. Staff A stated they then went and got a nurse. Staff A did not remember which nurse. Staff A stated the Assistant Director of Nursing (ADON) was there, the Administrator and Director of Nursing (DON) came and one of the Certified Meication Aides

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also came to the room. Staff A stated that basically the whole team came. Staff A stated that they are supposed to transfer people without the foot pedals (and leg rests) on the wheelchair. Staff A stated she was trained that way. Staff A stated she was trained at the facility and through her CNA training to remove the foot pedals prior to transfer. It's been a few years. Staff A stated the CNAs that were transferring this resident were Staff B, CNA who was from an agency and Staff C, CNA. Staff A stated she did not ask why the foot pedals were on. Staff A stated she did not receive education afterwards regarding the foot pedals and she did not know if the facility did education with the other 2 CNAs. Staff A stated she had not transferred Resident #2 prior to this incident and it was the first time she had assisted with transferring Resident #2. Staff A stated she had tried to get her leg up and over the foot pedal but Resident #2's leg was probably too heavy. After the whole thing was done, the next day the DON and the Administrator said that the pedals should have been off of the wheelchair when they talked to me about the whole situation.

On 5/9/23 at 11:52 a.m., Staff B stated that she was present with 2 other facility workers at the time of this incident. Staff B stated she was behind the wheelchair, and the other 2 were on either side of the wheelchair. Staff B stated Staff A and Staff B were both there at the beginning of the transfer. Staff B stated this resident's leg kind of slipped off to the side. Staff B stated she told Staff C that Staff C could push the red button and she could already be down. Staff B stated that Staff C then pulled the red button. Staff B stated the red button was on the Hoyer's pole at the bottom. Staff B repeated that she believed Staff A pulled the red button. Staff B stated that a lot of

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the facility's workers said it was okay to use the red button. Staff B stated it was iffy whether or not Resident #2's body was down in her wheelchair. Staff B stated the Hoyer arms weren't all the way down. Staff A stated this resident's bottom was in the wheelchair. Staff B stated this resident's skin had not broken open. Staff B stated they then were talking about lowering this resident the rest of the way, and then they were like, oh shoot, they saw that this leg had opened up. Staff B stated she immediately told Staff A and Staff C to call for a nurse. Staff B stated this resident's left leg was what had opened, and this resident's left leg was on the outside (of the leg rest), but it was nowhere near the pedal. Staff B stated that it wasn't the foot pedal that caused the injury as there were no sharp points on the foot pedal and there was cushions on the foot pedal. Staff B stated that the DON and the nurse couldn't figure it out. Staff B stated that nobody had said anything about moving the leg rests. With them (the facility) everything was backwards. Normally you would take the leg rests off prior to the transfer. Staff B learned this during CNA training. Staff B stated she had never seen a button like the one on the Hoyer, but she was told you could use the button for emergency purposes. Staff B stated she felt like this incident was an emergency. When asked why she felt it was an emergency, Staff B stated it was because this resident's leg was already to the side (of the leg rest/foot pedal). Staff B added she did not think they could have done anything differently at that point.

On 5/9/23 at 12:05 p.m., Staff A stated that the red button was not used during this situation. Staff A stated it was the agency CNA who had mentioned using it. Staff A stated she pointed at

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the red button and asked Staff B if that was the button she was talking about and she said it was. Staff A stated she did not push it. Staff A stated that Staff C was running the Hoyer lift and he kept lowering the lift the regular way. Staff A stated she went into the room just when they had Resident #2 over her wheelchair. Staff A stated she had only been told that they can use the red button only in case of an emergency.

On 5/9/23 at 12:50, the ADON stated she really was kind of a second set of hands at the point when she walked into Resident #2's room. The ADON stated she was hollered at and took off running. The ADON stated a Registered Nurse (RN), was the one who hollered for the ADON and they did grabbed the DON too. The ADON stated she went in to the room and noticed the significance of the wound, and stated this resident was bleeding. This ADON stated she then ran and got the treatment cart, sanitized her hands and grabbed 4X4 gauze, wound wash, normal saline and applied directly to the wound. This ADON stated she had put pressure on the wound and then had the other nurse sanitize and glove (her hands) and then sat an absorbent pad under this resident's leg. The ADON stated this resident did not complain of pain and verbalized she was okay. The ADON stated this resident would just say 'oh, oh,' and this resident was kind of scared. There were a lot of people in there just trying to take care of the wound. The ADON stated she applied slight pressure. The ADON stated this resident had thin skin. The ADON stated the ambulance came and transferred this resident out of the facility and they then cleaned everything up and sanitized the area. The ADON stated the ER sent Resident #2 right back and the ER staff said there was nothing they could do.

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The ADON stated she was not in the room for the transfer and the staff had her already Hoyered Resident #2 down into her wheel chair. The ADON stated the lift was still in this resident's room. The ADON stated she asked what happened and the staff said they were trying to adjust this resident's leg and that's when it happened. The ADON stated she did not see the transfer but the leg rests were already on the chair when the ADON went in with her leg kind of propped up on the foot rest. The ADON stated this resident had a tilt wheelchair, so the ADON had the staff tilt the resident back in her wheelchair so the ADON could assess the wound better. The ADPN stated the foot pedals should be removed from wheelchairs with transfers. The ADON stated they did a lot of education afterwards regarding the leg rest/pedals needing to be removed prior to transfers. The ADON stated this resident's wheelchair had calf rests too and this resident's leg rests attached to her wheelchair just below the seat. The ADON stated they are the hook and swing into place type of leg rests. The ADON stated they used a Hoyer lift for the transfer.

5/9/23 at 3:00 p.m., Staff D, CNA stated that prior to any transfers out of or into wheelchairs, she removes the leg rests off of the wheelchair. She stated that most wheelchairs have a bag on the back of them where the leg rests/wheelchair pedals can be placed.

On 5/9/23 at 3:17 p.m., Staff C, CNA, stated they were getting Resident #2 up for dinner(supper), from her bed to her wheelchair. Staff C stated he was operating the Hoyer and Staff B was turning Resident #2 toward her wheelchair. Staff C stated they got Resident #2 above her wheelchair

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and then Staff A saw them and came in to Resident #2 to help. Staff C stated they were lowering Resident #2 down (into her wheelchair) and then they realized her left leg was on the outside of the wheelchair pedal. Staff C stated that Staff A then tried to lift this resident's left leg up and over the left wheelchair pedal and the pedal kind of sliced Resident #2's leg open. Staff C stated they saw what he would call fat glands and then blood. Staff C stated there was nothing sharp on the wheelchair pedal, it was like the cut was from the fabric itself. Staff C stated the fabric was like normal wheelchair fabric, kind of like a tarp material. When asked if the red button was used, Staff C stated the only thing with the red button was that Staff A started to reach for it and Staff C told Staff A not to touch it and Staff A didn't touch it. Staff C stated that Staff B had told Staff A to push the red button. Staff C stated he had never been told they could use the red button, unless it was an emergency. The red button immediately lowers the resident down. Staff C stated they were supposed to have the leg rests off the wheelchair prior to the transfer and he knew that, but Staff B told Staff C to leave the leg rests on the wheelchair, and that it would be okay. Staff C reiterated that they were not supposed to have pedals on the wheelchair when they are transferring residents whatsoever. Staff C stated he had been at the facility approximately 1 ½ to 2 months. Staff C stated he was a fresh CNA. Staff C stated he thought Staff B knew what she was doing. Staff C stated he learned from this incident and he does not trust anybody anymore. Staff C stated they had training regarding all types of transfers after that. Staff C stated there were educational offerings for the next couple of weeks after this incident.

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| F 689 | Continued From page 9<br>On 5/9/23/ at 4:15 p.m., the Regional Director of Clinical Services acknowledged the concern regarding staff not removing leg rests/pedals prior to transferring Resident #2 to her wheelchair. This Corporate Nurse acknowledged that a wound resulted from not removing the leg rests.<br><br>On 5/9/23 at 4:35 p.m., the Administrator acknowledged the concern of the leg rests on the wheelchair at the time of the transfer. The Administrator stated the facility provided education on transfers following this incident. The Administrator did not have questions regarding this concern.<br><br>Resident #2 was in and out of the facility at the hospital when survey was taking place.<br><br>A Wound Evaluation dated 5/5/23, documented the laceration on the left shin measured 12.73 cm in length and 6.37 cm in width.<br><br>An In-Service Form dated 3/30/23, documented the education included that staff must be trained and be able to demonstrate competency using machines and devices to transfer a resident safely. It directed staff to remove pedals to wheelchair or move pedals to the side on wheelchair.<br><br>A Lifting Machine, Using a Mechanical policy revised on July 2017, documented that at least 2 staff are needed to safely move a resident wit a mechanical lift. It documented that a mechanical lift may be used for tasks that require transferring a resident from bed to chair. | F 689 | | |
| F 800 SS=D | Provided Diet Meets Needs of Each Resident<br>CFR(s): 483.60 | F 800 | F800 Provided Die Meets Needs of Each Resident | |

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| F 800 | Continued From page 10<br><br>§483.60 Food and nutrition services.<br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and record review, the facility failed to ensure that coordination of a resident's assessment and a resident's actual food needs was communicated among and between staff which resulted in dietary recommendations not being followed for 1 of 3 residents reviewed (Resident #3). The facility's dietitian recommended this resident have double entrée portions for meals and this recommendation was not implemented by the dietary manager. The facility reported a census of 68 residents.<br><br>Findings include:<br><br>A Quarterly Minimum Data Set dated 2/9/23, documented Resident #3's diagnoses included hip fracture, other fracture, and malnutrition. A Brief Interview for Mental Status (BIMS) documented a score of 15 out of 15, which indicated intact cognition. This resident was independent with set up help only for eating.<br><br>A Weight Change Notification dated 2/16/23 at 10:03 a.m., the Registered Dietitian (RD) documented that there was 8.3% weight loss within 90 days and 13.3 % weight loss within 90-180 days. The RD documented that she suspected the weight loss was related to fluid | F 800 | Northern Mahaska Specialty Care residents have the right to be provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br><br>Resident #3 dietary recommendation are followed.<br><br>Staff including agency staff have received education on dietary recommendations.<br><br>Facility has completed audit to ensure that all dietary recommendations are being followed.<br><br>Dietary Service Manager and/or designee will monitor dietary recommendations.<br><br>Facility will audit 3 residents per week x6 weeks that dietary recommendations are being followed and random audits thereafter.<br><br>Concerns identified will be reported and addressed in the facility QAPI committee meetings for additional intervention as indicated. | |

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| F 800 | Continued From page 11 | F 800 | | |

shift with bilateral lower extremities on admission and more recent no edema or trace lower extremity edema was documented. The dietitian documented that there was possible scale variances/inaccuracies contributing and possible inadequate nutrient intakes with increased nutrient needs related to wound healing contributing. The RD recommendations was that she would change double protein to double entrees with meals per this resident's request. A provider signed this form on 2/21/23.

On 5/4/23 at 2:28 p.m., the above recommendation for double entree was noted in Resident #3's chart. An observation at lunch earlier that day revealed this resident had one bowl of chili, the same as what most residents were served. When asked, this resident verified he had the one bowl of chili. Resident #3 stated he didn't know he was supposed to get double entrees. When asked if he would have eaten more chili, he stated yes, he would have liked to have had a second bowl of chili. He stated his daughter brings in food for him, so he gets extra food from her. When asked about him eating meals in his room, he stated he preferred it that way as he wanted to stay healthy so he could discharge home when he was able.

On 5/4/23 at 2:45 p.m., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were asked about the double entree/portions for this resident. They both stated they not know anything about this and said they would look into it. The DON went into the kitchen where the Dietary Manager (DM) was asked about this. The kitchen staff pulled this resident's card and it said regular diet on it. The DM and the cook stated it would have been written on the

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTHERN MAHASKA SPECIALTY CARE | 2401 CRESTVIEW DRIVE OSKALOOSA, IA 52577 |

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card after diet that he was to have double entrees with meals, if that would had been communicated. The DM and the Staff E, Cook both stated they were not aware that this was a recommendation. The DM stated the process for updating diets was that the DM would receive any updates from nursing through the PCC (the facility's electronic health record). Then the DM would update the diet and change the card. The DM stated each resident has a card.

On 5/8/23 at 3:23, the RD stated in her personal opinion the MNA (Mini Nutritional Assessment) tool is hard to capture a residents' status correctly. The RD stated Resident #3 flagged for being malnourished because of weight loss, acute stress, and mobility. The RD stated that Resident #3 was on a NIP (Nutritional Interventions Program). She stated that Resident #3's specific interventions are double entree with meals. This RD stated she met with him in February and that is when the double entrée with meals was put into place. This RD stated they send out RD recommendations to the team every week. She stated the recommendations go out to the DM and the DM is the one that is supposed to see the recommendations and initiate them. The RD stated Resident #3 was initially on double protein and then wanted to go to double entree instead. She stated that Resident #3 had an initial weight loss. He had edema when he initially came in and there could be variables with different scales to weigh. She stated that obviously isn't good and stated she knew the facility was looking at weighing each resident the same way. The RD stated Resident #3 was still triggering for a significant weight loss at 6 months. The DM stated that the nurses get the information if a dietitian's recommendation

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| F 800 | Continued From page 13 | F 800 | | |

required a doctor's order. She stated in that case the nurses would then get those orders to the DM. The RD stated that the NIP was basically a food based approach. She stated they would try this prior to recommending protein drinks or supplements which require a doctor's order.

On 5/8/23 at 4:00 p.m., the DON and the Regional Director of Clinical Services acknowledged the concern of the facility not following dietary recommendations of double entrees since it was communicated back in 2/20/23. They acknowledged this was a concern and that it could play a part in wound healing and increasing of strength to regain mobility.

On 5/9/23 at 4:35 p.m., the Administrator acknowledged the concern regarding a recommendation for Resident #3 to have double entrees with meals was not put into place.

A Therapeutic Diets policy revised October 2017, documented that diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. It documented that the diet order should match the terminology used by the food and nutrition services department. It documented that the dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets.

A NUTRITION INTERVENTION PROGRAM from the Dietary Services Policy & Procedure Manual February 2016 Edition,
documented the following:
POLICY: Residents identified with a decline in their nutritional status will be placed on a Nutritional Intervention Program (NIP).

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| F 800 | Continued From page 14<br>High risk residents may include:<br>-Residents who have had a significant weight loss defined by 5% in one month, 7.5 % in 3 months, 10% in 6 months or gradual weight loss over a longer period of time.<br>-Residents with open/pressure area(s).<br>-Residents with poor nutritional status or inadequate oral intake.<br><br>PROCEDURE:<br>1. Consulting Dietitian, Dietary Services Manager (DSM) and/or DON will initiate one and/or a combination of the products listed below to increase calories and/or protein for residents who are at nutritional risk. A doctor's order is not needed for the addition of the NIP.<br>Any one and/or any combination of the following food items may be used to promote weight gain, wound healing and/or improved nutritional status.<br>-Super Cereal<br>-Two slices bacon or sausage in addition to regular menu<br>-Extra egg daily<br>-Whole milk<br>-Peanut Butter (may whip butter into the peanut butter for even more calories and to promote easier swallowing)<br>-Cream Cheese<br>-Extra margarine on all hot foods or squeeze bottle at the table<br>-Extra ounce meat at lunch and dinner<br>-Ice Cream/sherbet<br>-Sour Cream<br>-Cottage Cheese<br>-Slices of cheese<br>-Puddings/custards<br>-Yogurt<br>-Half and Half<br>-Other high calorie additions resident may desire | F 800 | | |

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| F 800 | Continued From page 15<br>For best results the resident should be involved in deciding what food items to incorporate into his/her NIP whenever possible.<br>Commercial supplements are appropriate for residents with pressure areas, extreme weight loss and/or with abnormal lab values as deemed appropriate by the Consulting Dietitian.<br>Commercial supplement require a doctor's order.<br>2. The Consulting Dietitian will routinely evaluate approximate extra calories and protein provided by the NIP.<br>3. Interventions will be documented on the resident's Care Plan, including NIP, commercial supplements, and fortified foods.<br>4. Residents receiving the NIP may be identified with a particular designation on their dietary card and/or by a particular color napkin/placement. | F 800 | | |

Care Initiatives

# In-Service Form

**Date: 6/6/23**

## Education Description:

Assessment of nutritional needs, aids in the development of an individualized care plan for nutritional interventions and help support integrity of the skin through nutrition hydration. If resident intake continues to be inadequate, impractical, or impossible, nutritional support must be implemented according to the plan of care. The dietician in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places resident at risk for impaired nutrition. Interventions for the resident with wounds or at risk for developing wounds may include providing enough calories to stabilize weight and ensure adequate protein intake given the residents current weight and clinical situation. A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietician as part of treatment for a disease or clinical condition to modify specific nutrient in the diet, or to alter the texture of a diet. The resident has the right to not comply with therapeutic diets. Response to diet changes will be documented in the chart.

| Print Name | Position | Signature |
| --- | --- | --- |
| [redacted] | [redacted] | [redacted] |

Care Initiatives

# In-Service Form

Date: 3/30/23

**Education Description:** Mechanical Lifting Machine for Transfers: Sit to stand lifts requires only one staff member to operate, unless resident prefers two staff and Hoyer mechanical lifts require two staff for transfer. Staff must be trained and be able to demonstrate competency using machines and devices to transfer a resident safely. Remove pedals to wheelchair or move pedals to the side on wheelchair. Appropriate size of sling related to the resident size and task will be selected. An unobstructed path for the lift machine will be clear, ensure their enough room to transfer, and lift is at the correct height. Ensure battery is charged. Make sure lift is stable and locked. Ensure sling, hooks, chains, straps, and supports is in good working condition. Ensure there are no tears or rips in sling. Place sling and lower machine with bar closer to residents. Attach sling to lift. Make sure sling is secured and properly balanced, check to make sure resident is supported, double check security of sling attachment, exam hooks, clips, or fasteners, and ensure the sling bar is securely attached. Start to lift resident to check stability, check the resident comfort level, and slowly lift resident. Once transfer destination is reached, lower residents and ensure sling bar does not hit residents. Detach sling from lift and carefully remove sling and position resident.

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