

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|---|--|
| S 000 | Initial Comments IRI of 2/14/17/IL92172 | S 000 | | |
| S9999 | Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care | S9999 | Attachment A Statement of Licensure Violations | |

| | | |
|---|-------|------------------------------|
| Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/22/17 |
|---|-------|------------------------------|

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S9999 | <p>Continued From page 1</p> <p>b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>Based on observation, interview and record</p> | S9999 | | |

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|---|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S9999 | <p>Continued From page 2</p> <p>review the Facility failed to perform safe transfer techniques to prevent accidents and injuries for 2 residents (R1 and R2) reviewed for transfers. This failure resulted in R2 falling from a sit to stand mechanical lift and sustaining a head injury requiring 5 staples.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. R2's Physical Therapy Plan of Care Notes with a start date of 10/26/2016 document in part, "The patient has shown a decline in safe transfer status recently due to medically complex conditions resulting from dementia and weakness. Therapy Necessity: Therapy necessary for transfer training to improve safety with transfer for patient and staff. Without therapy patient at risk for greater dependence of care and loss of toileting on commode. Functional Deficit Other: Patient requires constant verbal cues during use of stand lift transfers to stand up and keep hands safely in lift. Current Level of Function: This patient is able to safely complete transfers requiring stand lift with maximum verbal and tactile cues to stand upright and maintain proper hand placement." This document was signed by Z1, R2's Physician, on 11/8/2016. <p>R2's Minimum Data Set (MDS) dated 11/25/2016 document R2's Brief Interview for Mental Status (BIMS) score was a 5 out of 15 (severely impaired). R2's MDS documents she requires extensive assistance of one staff person (3/2) for transfers.</p> <p>Occupational Therapy (OT) Note signed by E14, Certified Occupational Therapy Assistant (COTA) on 12/14/2016 document in part, "Guided patient to transfer to bed with use of sit to stand lift with staff present."</p> | S9999 | | |

Illinois Department of Public Health

| | | | | | |
|---|--|--|---|--------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
| NAME OF PROVIDER OR SUPPLIER OAK HILL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| S9999 | Continued From page 3 R2's OT Note signed by E15, COTA on 12/15/2016 document in part, "Instructed patient in functional transfer training from bed to wheelchair with the use of sit to stand lift. Educated patient to pull up more with handles to relieve pressure under arms. Patient took hand off lift when initially starting to stand, verbal cue and assist provided for replacement of right hand on grab bar. Patient did not attempt to remove hand again." R2's Progress Note, dated 12/19/2016, document at 6:21 PM "Resident is not doing well with the sit to stand. She refuses to keep arms and hands on the lift. She is screaming a lot during attempts at transferring with sit to stand. The CNA (Certified Nurse's Aide) has to manually lift her because she refuses to use the sit to stand." R2's OT Note signed by E15 on 12/19/2016 document in part, "Staff educated that patient is to resume sit to stand lift and to call if experiencing any difficulty." R2's OT Note dated 12/23/2016 document R2 was discontinued with OT using stand lift and positioning. R2's Progress Note, dated 12/25/2016, document at 4:52 PM, "Resident is continuing to put arms inside of sit to stand and slides right out of sling; it takes 2 people to get her up so she doesn't fall out of sling." There is documentation in the Progress Notes on 12/25/2016, that R2 was having difficulty using the sit to stand but there is no documentation in the OT notes of staff notifying them of any difficulty. R2's Progress Note, dated 02/14/2017, | S9999 | | | |

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|--|-------|--|--|
| S9999 | <p>Continued From page 4</p> <p>documents at 10:01 PM, "CNA reported to this nurse that resident had slid out of the sit/stand lift sling by tucking her arms inside the sling; resident had hit her head and bleeding couldn't be controlled; MD (Medical Doctor) was notified and resident was sent to the ER (Emergency Room)."</p> <p>Emergency Hospital Records with the Arrival date of 02/14/2017 document R2 had a head injury with a head laceration measurements at least 4.9 centimeters (cm) by (x) 2.6 cm x 2.0 cm. Staples were not documented.</p> <p>R2's Progress Note, dated 02/14/2017, documents at 11:04 PM, "Resident arrived back to facility at 10:35 PM. In bed resting at this time. Checks every 4 hours to staples initiated. Denies pain at this time."</p> <p>R2's Progress Note, dated 02/22/2017, at 6:13 PM documents "5 intact staples removed with assistance from CNA."</p> <p>The Facility's Incident Report, dated 02/14/2017, at 6:45 PM documents "CNA reported resident slid her arms inside sit to stand sling and slid out of sling; hit head, sent to Emergency Room." The Report documents Corrective Action Taken as "Need mechanical lift. Will now be mechanical lift for safety."</p> <p>On 03/01/2017 at 2:43 PM, E4, CNA stated "I strapped her (R2) stand up lift and as I was pushing (R2). She let go of the handles and slid through the straps and fell backwards. I don't usually take care of her. I usually work the Alzheimer Unit and that night I was filling in for another CNA as she had a death. No one informed me that sometimes she (R2) lets go of the handles."</p> | S9999 | | |
|-------|--|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|---|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 5</p> <p>On 03/01/2017 at 1:20 PM, E5, Program Manager for Occupational Therapy (OT) stated "We started trials on (R2) because she had been ill and we working her back to a stand lift and doing transfer trainings. We were still actively seeing her until 12/25/2016. I know we had a lot of discussions during her treatments. (R2) was discharged on 12/23/2016 with a sit to stand. I do not see any documentation after 12/25/2016 of any communication (R2) having difficulty with stand lift transfers."</p> <p>On 03/01/2017 at 3:10 PM, E2 stated when a resident has changes such as their sit to stand ability and is declining most of the time it is the Restorative Nurse who makes the changes and would perhaps change to a mechanical lift. When asked if she was aware of R2 having any difficulties with transfer she stated "I knew she was in therapy but she was released. She was approved for a sit to stand. I am not sure why she was not changed to a mechanical lift before the fall. I will have to look. I thought she was being seen in therapy. I expect staff to tell us if residents are having changes."</p> <p>On 03/02/2017 at 8:59 AM, E2, Director of Nursing (DON) stated if residents were having issues with the sit to stand E5, Program Manager, OT, would be the person who be notified.</p> <p>On 03/03/2017 at 9:09 AM, E2 stated she did not personally tell Z1, R2's Physician, of R2 having issues with not holding on to the handles with the sit to stand. E2 stated "I could not tell you if anyone told (Z1) she (R2) was having problems."</p> <p>On 03/02/2017 at 12:03 PM, Z1, Physician of R2 stated "If a resident was no longer able to hold on</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S9999 | Continued From page 6 to the handles for a sit to stand I would expect the staff to notify me of the changes of the resident and have the resident changed to a mechanical lift. I was not aware (R2) was having issues with the inability to hold on the handles and the staff/aids had not shared with me any inconsistencies or the inability for (R2) to hold on to handles." On 03/03/2017 at 9:44 AM, Z2, Manufacturer Safety Director of mechanical Lift stated "If the patient cannot support their own weight they should be put on a sit to stand body mechanical lift." The Safe Lift Policy dated 7/2006 document "Purpose: This policy is intended to maximize the safety of residents and staff during the lifting and transferring procedure." The policy documents "4. Changes in the resident's condition must be reported to the charge nurse. The therapy department, Care Plan Nurse and Charge Nurse will re-evaluate the method of transfer. If changes are indicated the above procedures will be completed." The Policy documents "Class 3 - Extensive Assistance- Mechanical Stand Up Lift 3. Residents in most cases should be able to grasp handles of the lifting device. 4. Resident must be cognitively able to follow directions in order to cooperate with the use of the equipment." R2's Care Plan with a Start Date of 02/23/2017 document in part, "Increased susceptibility to falling that may cause physical harm. Related to history of falls (1-2 in past 3 months), age, use of assistive device (walker), visual or hearing difficulties, incontinence, impaired physical mobility, cognitive impairment, wheelchair use, poor safety awareness, poor standing balance, | S9999 | | |

Illinois Department of Public Health

| | | | |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|---|-------|--|--|
| S9999 | <p>Continued From page 7</p> <p>poor insight into deficits. Approach documents "Date 12/01/2016 Transfer assist with 1 and stand up lift. Sit to stand lift for transfers."</p> <p>On 03/01/2017 at 9:31 AM, E6 and E7 transferred R2 using a large mechanical lift sling and full body mechanical lift. Staff did not check the sizing of the sling, pause or pull on sling for safety. R2 was moaning out and yelling stating "Oh, please don't drop me. Promise me you will not drop me."</p> <p>On 03/01/2017 at 9:38 AM, E6 was asked what size sling was being used on R2 and he stated "The large sling."</p> <p>The Manufacture Guidelines of the mechanical lift used to transfer R2 documented staff should utilize a medium sized sling to transfer a person weighing 100-210 pounds. The Guidelines document a large sling should be used for persons weighing 210-310 pound person.</p> <p>R2's Vitals Report document R2 was last weighed on 02/27/2017 and document R2 at 187.6 pounds.</p> <p>2. R1's diagnoses from Electronic Medical Record (EMR), undated, documents in part Hemiplegia following unspecified Cerebrovascular disease affecting right dominant side.</p> <p>R1's MDS dated 12/8/2016 documents BIMS score of 15 out of 15 cognitively intact. The MDS also documents that R1 is a one person physical assist and has impairment on one side of upper and lower extremities.</p> <p>On 3/2/2017, at 9:21 AM, R1 was sitting in her wheelchair. E9 and E10, CNAs approached R1 to</p> | S9999 | | |
|-------|---|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| S9999 | <p>Continued From page 8</p> <p>transfer R1 from the wheel chair to the bed with a mechanical sit to stand lift. After placing the sling to R1 and fastening it around her abdomen, and placing the strap around R1's legs, E9 instructed R1 to take hold of the handles of the mechanical lift. R1 held onto the lift with her right hand and her left arm dangled flaccid as E10 raised the lift to a standing position and transported R1 to the bed.</p> <p>On 3/2/2017 at 9:25 AM, E9 and E10 placed the sling around R1's abdomen and placed the strap around R1's legs, R1 was instructed to hold onto the handles of the lift. R1 held onto the lift with her right hand and her left arm dangled flaccid as E10 raised the lift to a standing position and transported R1 from her bed to the wheelchair.</p> <p>On 3/2/2017 at 10:30 AM, E8, Restorative Registered Nurse (RN) was asked if someone cannot hold onto a sit to stand mechanical lift during transfer if she would expect staff to continue with the sit to stand transfer. E8 replied, "No." E8 was asked if she expected staff to stop and check the belt for correct position after it was applied, E8 stated, "Yes I expect them to stop and check the belt for correct positioning."</p> <p>The Safe Lift Policy dated 7/2006 document "Purpose: This policy is intended to maximize the safety of residents and staff during the lifting and transferring procedure." The policy documents "4. Changes in the resident's condition must be reported to the charge nurse. The therapy department, Care Plan Nurse and Charge Nurse will re-evaluate the method of transfer. If changes are indicated the above procedures will be completed." The Policy documents "Class 3 - Extensive Assistance- Mechanical Stand Up Lift 3. Residents in most cases should be able to</p> | S9999 | | |

Illinois Department of Public Health

| | | | |
|--|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006274 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 03/03/2017 |
|--|--|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER OAK HILL | STREET ADDRESS, CITY, STATE, ZIP CODE 623 HAMACHER STREET WATERLOO, IL 62298 |
|---|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
|--------------------|--|---------------|---|--------------------|

| | | | | |
|-------|--|-------|--|--|
| S9999 | Continued From page 9 grasp handles of the lifting device. 4. Resident must be cognitively able to follow directions in order to cooperate with the use of the equipment." (B) | S9999 | | |
|-------|--|-------|--|--|