STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11120951	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEHIGH ACRES HEALTHCARE & REHAB CENTER	1550 LEE BOULEVARD , LEHIGH ACRES, Florida, 33936

(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) COMPLETION DATE
N0000	INITIAL COMMENTS An off-hour relicensure survey with complaint #2025007239 was conducted 6/15/25 through 6/21/25 at Lehigh Acres Healthcare & Rehab Center, a nursing home in Lehigh Acres, Florida. Deficiencies were identified at the time of the survey. A Class I deficiency was identified at tag N201. A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. Resident #48 had a history of multiple strokes with weakness to one side of the body. The resident required the use of a sit to stand lift with substantial to maximal assistance of staff. On 5/2/25 the nurse on duty documented the resident was crying and in a lot of pain. She stated the previous night the lift was used wrong and she sustained an injury to her left foot. The resident's foot was swollen with purple bruising. On 5/3/25 an X-ray of the resident's left ankle showed a left calcaneal (heel) fracture of indeterminate age. The facility had no documentation staff who use mechanical lifts to transfer residents had the appropriate training and competencies to safely use the lifts.	N0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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N0000	Continued from page 1 This lack of knowledge and ability created a likelihood of serious harm, serious injury or death of all 29 residents care planned for lift transfers due to improper use of the lifts and resulted in the Class I deficiency. On 6/19/25 at 5:45 p.m., the Administrator was notified of the Class I deficiency. The following is a description of the deficiencies found at the time of the visit.	N0000		
N0054 SS = D	Follow Physician Orders CFR(s): 59A-4.107(5), FAC All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review, resident and staff interview and observations the facility failed to deliver the prescribed oxygen amount for 1 (Resident #60) of 6 residents sampled. The findings included: Review of the clinical record for Resident #60 revealed a physician's order dated 1/23/25 for oxygen to be delivered at 3 liters per minute via nasal cannula with humidifier for a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). On 6/15/25 at 10:30 a.m., in an interview, Resident #60 stated that his oxygen was to be set at 3 liters per minute. He said he was unable to get up and check the oxygen himself so he counted on the staff to make sure the concentrator was set at 3 Liters. Observation of the oxygen concentrator during the interview revealed it was set at 4 Liters (L) and had no humidifier. "Photographic evidence obtained" On 6/16/25 at 10:15 a.m., and 6/17/25 at 12:15 p.m., Resident #60 was observed in bed in his room. Resident	N0054	On 06/18/2025 resident #60 was assessed by the DON/Designee confirming oxygen delivery is being provided in accordance with physician orders. All residents residing in the facility requiring supplemental oxygen have the potential to be affected. The DON/Designee will review all current residents requiring supplemental oxygen by 07/18/2025 to ensure that oxygen is delivered in accordance with physician orders, with corrective action immediately upon discovery. Licensed nurses will be re-educated by the DON/Designee regarding the delivery oxygen in accordance with physician orders. 07/25/25. The DON/Designee will audit ten residents requiring oxygen weekly times four weeks and then five residents requiring oxygen weekly times eight weeks to ensure that oxygen delivery is provided in accordance with physician orders. The results of these audits will be submitted to the QAPI committee monthly for review and further recommendations. Date of completion is 07/25/2025.	07/25/2025

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N0054 SS = D	Continued from page 2 #60 was receiving oxygen via nasal cannula. Observation of the oxygen concentrator revealed the oxygen was set at 4 liters per minute. No humidification On 6/17/25 at 12:15 p.m., in an interview Licensed Practical Nurse (LPN) Staff Q said Resident #60's order for oxygen is 3 liters per minute with humidification. LPN Staff O verified the oxygen concentrator was set at 4 liters and said it should be at 3 liters. She also verified the humidifier was not on. When asked if she looked at the oxygen when she came on duty she said, "I am not going to lie. I didn't." Class III	N0054		
N0201 SS = K	Right to Adequate and Appropriate Health Care CFR(s): 400.022(1)(l), FS (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, residents and staff interviews, the facility failed to implement ongoing training, competencies and supervision of staff to ensure the safe use of manual and mechanical lifts to prevent avoidable accidents for 1 (Resident #48) of 29 residents care planned for manual or mechanical lift transfer. Resident #48's diagnoses included obesity, history of multiple strokes and functional limitation in range of motion of upper and lower extremities on one side. On 5/2/25 the nurse on duty documented the resident was crying and in a lot of pain. Her ankle was swollen with purple bruising. Resident #48 reported she sustained the injury to her foot the previous night when the lift "was used wrong." Resident #48 was diagnosed with a fracture of the left heel bone.	N0201	On 06/20/2025 Resident #48 was assessed by the DON/Designee, no additional issues were identified. On 6/19/2025 the Administrator reported the incident to AHCA, DCF, and law enforcement as required with a thorough investigation initiated. On 6/30/2025 the Administrator reported the incident involving the lift to the FDA in accordance with the Safe Medical Device act of 1990. Resident #33 lift pad was immediately taken out of service and replaced upon discovery on 6/21/2025. All current residents requiring the use of mechanical lifts have the potential to be affected. The DON/Designee audited all residents in the facility; 45 residents were identified that require the use of facility lifts. All 45 residents were assessed on 06/20/2025 with no injuries noted. The DON/designee assessed all mechanical lift slings on 06/21/2025, to ensure all lift slings were in proper working condition with any findings addressed as identified. The DON/ADON have reviewed, revised and implemented new competency evaluation forms for all facility lifts to provide more specific instructions on 06/19/2025.	07/25/2025

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N0201 SS = K	Continued from page 3 The facility had no documentation staff using manual and mechanical lifts to transfer Residents were trained and competent to safely use the lifts. This lack of knowledge and ability presented an imminent danger and substantial probability of serious physical harm or death from unsafe use of the lifts for all 29 residents care planned for manual and mechanical lift transfers and resulted in the determination of the Class I deficiency. The findings included: Review of the clinical record revealed Resident #48 had a date of admission of 10/18/21. Review of the Annual Minimum Data Set (MDS) assessment with a target date of 5/12/25 revealed Resident #48 scored "15" on the Brief Interview for Mental Status (BIMS), indicating the resident's cognitive skills for daily decision making were intact. The resident had functional limitation in range of motion of the upper and lower extremities on one side of the body. Review of the care plan initiated on 11/10/21 and revised on 9/19/24 revealed Resident #48 was at risk for falls and/or fall related injury related to history of multiple strokes, generalized weakness, impaired balance, and unsteady gait. Resident #48 required staff assistance with transfers and ambulation. The interventions included to provide hands on assistance with transfers and utilize (brand name) manual standing aid as ordered. Review of the nursing progress notes revealed on 5/2/25 at 10:27 p.m., Licensed Practical Nurse (LPN) Staff O documented in a change in condition progress note, "Nursing observations, evaluations, and recommendations are: Resident is crying in a lot of pain. Her left ankle is swollen and has purple bruising. She stated, "We were using the (brand name) lift last night and it was used wrong." LPN Staff O documented the Advanced Practice Registered Nurse (APRN) was notified on 5/2/25 at 10:42 p.m. and ordered a STAT (Immediate) X-ray of the resident's left ankle.	N0201	Continued from page 3 The DON/Designee will educate Licensed Nursing Staff, Certified Nursing Assistants, Physical and Occupational therapist regarding the proper use of all facility lifts by 07/25/2025. All new employees will receive the training as part of their new hire orientation. The DON/Designee will audit ten residents requiring mechanical lifts weekly times four weeks and then five residents requiring mechanical lifts weekly times eight weeks to ensure the safe use of facility lifts to prevent avoidable accidents. The Administrator/Designee will submit the audit findings to the QAPI Committee monthly for review and further recommendations. Date of completion is 07/25/2025	

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N0201 SS = K	Continued from page 4 Review of the "Radiology Results Report" of the resident's left ankle X-ray revealed the STAT X-ray was not done until 5/3/25 at 10:24 a.m. The results reported on 5/3/25 at 2:20 p.m., read, "Left calcaneal (heel bone) fracture. The age of the fracture is indeterminate." On 6/15/25 at 9:35 a.m., in an interview Resident #48 said she sustained a fracture of the left foot when her foot got stuck between the lift and the wheelchair during transfer. She said the Certified Nursing Assistant (CNA) did not place her feet correctly on the lift. Her left foot slipped off the lift and caused the injury. Resident #48 said she could not walk or stand. She tried but was not able to lift her feet or move her legs. She said, "My foot was not on right. I told them that but they didn't fix it. My foot went between the lift and the floor." On 6/17/25 at 3:40 p.m., in an interview, the Director of Nursing (DON) said she was out of town on 5/2/25 and did not know about Resident #48's left calcaneal fracture from the manual lift. The DON looked in the facility's incident investigations and said there was no documentation the incident was investigated. On 6/17/25 at 4:30 p.m., in an interview Resident #48 said staff were still using the manual lift to transfer her. She said when she injured her left foot, 2 staff were transferring her with the lift. They were not paying attention. Her foot was not placed properly in the machine and moved. Her foot got stuck and twisted and caused the left heel bone fracture. On 6/17/25 at 4:45 p.m., in an interview the Administrator said no one called him on 5/2/25 to report the incident. When the nurse told him about it on 5/5/25, he started an investigation but could not locate it. He said they started re-educating staff on the lifts. When asked to see documentation of the training, he said, "Like I said, I can't find anything." On 6/17/25 at 4:50 p.m., in an interview the Social Service Director said when there is an incident involving a resident, she is the one who interviews the affected resident. She said on 5/5/25 she became aware of Resident #48's left heel fracture and interviewed	N0201		

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N0201 SS = K	Continued from page 5 her. She said Resident #48 told her the injury happened when CNA staff G and another CNA transferred her with the (brand name) manual lift. She wrote the resident's statement but could not find it. On 6/17/25 at 5:40 p.m., the DON was interviewed about facility processes related to safe use of the manual and mechanical lifts to ensure residents' safety during transfer with manual and mechanical lifts and prevent avoidable accidents. The DON said as part of orientation all staff watch a video on the use of the different lifts used at the facility. The therapy department evaluates residents to determine the transfer status, including the type of lift appropriate for each resident as necessary. Requested documentation of training for CNA Staff G who was assigned to Resident #48 on 5/1/25. Review of the employee file for CNA Staff G revealed a date of hire of 8/29/2018. There was no documentation of manual or mechanical lift training on orientation. A "Competency Assessment-Mechanical lift" from a previous company dated 1/11/19 was in CNA Staff G employee file. The form was not signed by CNA Staff G or reviewer. The form contained several questions. A question mark was entered for: Able to demonstrate appropriate set up of mechanical lift. A "2" (supervision required) was documented for: Demonstrates ability to transfer from bed to chair and chair to bed using mechanical lift. "Not done" was entered for: "Demonstrates ability to transfer from floor to bed or chair using mechanical lift" and "demonstrates ability to transfer from chair to toilet using mechanical lift". On 6/17/25 at 5:50 p.m., in an interview CNA Staff G said it has been 7 years since she's had training for mechanical lifts. On 6/17/25 at 6:00 p.m., in a telephone interview CNA Staff P said she took care of Resident #48 on 5/2/25 from 7:00 p.m. to 7:00 a.m. She said that day Resident	N0201		

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N0201 SS = K	Continued from page 6 #48 requested to put her to bed earlier than her usual time of 8:30 p.m. She said Resident #48 said her ankle got injured the previous night when they transferred her with the manual lift. Resident #48 told her the CNA who transferred her didn't know what she was doing. CNA Staff P said she immediately notified Licensed Practical Nurse (LPN) Staff O. The DON was present during the telephone interview conducted on speaker phone. On 6/18/25 at 8:19 a.m., CNA Staff E and CNA Staff F were observed using the (brand name) manual sit-to-stand lift to transfer Resident #48 from bed to chair. The CNAs brought the manual lift to the bed and helped the resident place her feet on the footrest of the lift. Resident #48 was not able to pull herself in a standing position without extensive assistance of both CNAs. The CNAs stood on opposite sides of the resident. Both CNAs pulled the resident to a standing position on the lift. Resident #48 was able to grab and hold onto the handlebar during the transfer with the lift. On 6/18/25 at 9:20 a.m., a joint interview was held with the Administrator and the DON about facility processes to investigate residents' incidents and accidents, and the lack of investigation related to Resident #48's incident during transfer with the manual sit-to-stand lift. The Administrator said he found the staff statements related to Resident #48's accident. He said, "Her foot slipped, it was an accident." He provided employee statements related to the Resident #48's incident and said the statements were the investigation. He said based on what Resident #48 said he did not need to interview anyone else. Review of the statements revealed: On 5/5/25 the Social Services Director wrote on a signed statement, "Visited resident regarding her foot (ankle) and she stated that when (CNA Staff G) and another CNA changed her briefs, her left foot slid and hit her ankle on the bar (to open and close) of the (brand name lift). She stated that this happened on Thursday May 1, 2025 @ (at) around 5 or 6 pm." On 5/5/25 LPN Staff Q wrote on a signed statement, "I	N0201		

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N0201 SS = K	Continued from page 7 was the nurse assigned to the resident (Resident #48's name) on 5/5/25. She told me that when the CNA was transferring her to the bathroom using the (brand name manual lift) that she hit her left ankle on it. At the time she could not remember the name of the CNA." There was no documentation LPN Staff Q documented the interview with the resident or completed an incident report. On 5/5/25 CNA Staff G wrote on a signed statement, "I did not take the resident to the bathroom on Thursday 5/1/25 and she did not hit her left ankle with me or reported anything to me about her ankle. The first time I'm hearing about it is today." On 5/5/25 LPN Staff R wrote on a signed statement, "On 5-2-25, I was the nurse assigned to (Resident #48) 7A-7P (7:00 a.m. to 7:00 p.m.). During my shift resident did not complain of pain." One other CNA (CNA Staff S) signed a statement dated 5/5/25 noting she had not heard anything about Resident #48 hurting her foot. Review of the nursing staffing schedule for 5/1/25 revealed 4 CNAs worked on the unit where Resident #48 resides during the 7:00 a.m., to 7:00 p.m. shift. Only one of the 4 CNAs was interviewed. There was no statement from LPN Staff O. On 6/18/25 at 9:30 a.m., the Director of Rehab provided documentation of a discharge from therapy summary for Resident #48 dated 10/30/23, a Quarterly Physical/Occupational Therapy Screening form dated 9/17/24, a Quarterly Physical/Occupational Therapy Screening form dated 5/12/25, and Change of Status Physical/Occupational Therapy Screening form dated 6/18/25. Review of the discharge from therapy summary dated 10/30/23 revealed one of the therapy goals was to increase bilateral lower extremities strength to 4 minus out of 5 to facilitate patient's ability to perform sit to stand transfers with moderate assistance	N0201		

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N0201 SS = K	Continued from page 8 and 25% verbal cues with use of grab bars/manual standing aid (brand name sit-to-stand lift) while maintaining functional posture in order to decrease level of assistance from caregivers. The therapy discharge noted Resident #48 achieved a 3 minus out of 5 for the bilateral lower extremities strength and was total dependence for sit to stand. Review of the Quarterly Physical/Occupational Therapy screening form dated 9/17/24 noted Resident #48 was reviewed for changes in functional status. Resident #48 remained appropriate for the (brand name) sit-to-stand lift. The source for the screening information was "staff interview". Review of the Quarterly Physical/Occupational Therapy screening form dated 5/12/25 noted "no change in condition" and "No functional decline indicated." The source of the information was "staff interview." Review of the Physical/Occupational Therapy screening form dated 6/18/25 noted the screen was done for a change in transfer status for Resident #48. The Physical Therapy Assistant documented, "Observed nursing staff perform (brand name manual sit-to-stand lift) with patient for safety For transfers and toileting." No information regarding Resident #48's ability to use the lift was documented. On 6/18/25 at 9:35 a.m., in an interview the Director of Rehab said a therapy screen did not necessarily involve an observation of the resident. She said, "In that case it was talking with the staff." On 6/18/25 at 9:40 a.m., in an interview the Physical Therapy assistant who conducted the screening on 6/18/25 said he observed the Director of Nursing and a CNA transfer Resident #48 with the (brand name) sit-to-stand manual lift. He said they did a great job. He verified the screening did not reflect the resident's ability to use the lift but said Resident #48 was able to do it correctly. On 6/18/25 at 9:55 a.m., the DON provided a yearly performance appraisal for CNA Staff G dated 9/9/24. The form noted CNA Staff G scored "3" (average) in "Personal Nursing Care Functions" which included, "Assist with lifting, turning, moving , positioning,	N0201		

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N0201 SS = K	Continued from page 9 and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts, etc." The DON verified there was no competency evaluation for the use of the manual or mechanical lifts or how the rating of "3" listed on the form was determined. She said CNA Staff G trained new CNAs which includes showing them how to use the lifts. She said she considered this an evaluation of the CNA's ability to use the manual and mechanical lifts since CNA Staff G was evaluating new CNAs. On 6/18/25 at 2:22 p.m., in an interview LPN Staff T said she received training on the manual sit-to-stand lift 3 years ago. LPN Staff T was not able to explain or demonstrate how to use the manual sit-to-stand lift. She said, "I don't know how to use the lift, I have never used it." On 6/19/25 at 11:21 a.m., CNA Staff E and CNA Staff V were observed using a (brand name manual sit-to-stand lift) to transfer Resident #32 from bed to the wheelchair. Resident #32 was wearing tennis shoes. He sat on the edge of the bed with his feet on the floor. CNA Staff E placed herself on the resident's right side and CNA Staff V placed herself on the resident's right side. The CNAs positioned the (brand name) manual sit-to-stand lift in front of the resident. The CNAs instructed the resident to place his feet on the footrest and his hands on the handlebar. The resident placed only the front part of his feet on the footrest of the lift with the heels hanging off the back of the footrest. The resident's feet were not completely supported by the footrest. Resident #32 stood up with his heels off hanging off the footrest. The CNAs rotated the half seats underneath the resident's buttocks and transported the resident in the manual sit-to-stand lift with his heels hanging off the footrest. The CNAs did not ensure the resident's feet were properly placed on the footrest before wheeling the resident to the wheelchair. CNA Staff E moved over to the wheelchair. CNA Staff V transferred Resident #32 with the heels hanging off the back of the footrest. "Photographic evidence obtained." Review of the instructions for use for the manual sit-to-stand lift provided by the representative via email revealed, "Patient/Resident Assessment . . . Before use, the caregiver should always consider the patient's/resident's medical condition as well as	N0201		

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N0201 SS = K	Continued from page 10 physical and mental capabilities. In addition, the patient/resident must: . . . Have the ability to stand unaided or stand with minimal assistance. . . Safety instructions . . . This mobile lift must be used by a caregiver trained with these instructions . . . Before transferring the Patient . . . Position the (brand name lift) so that the patient's feet are placed on the footrest with knees comfortably against kneepad. . ." Review of the manufacturer's skills checklist and performance observation revealed, "The patient's/resident's feet should be on the footrest with knees comfortably against kneepad during transfer" On 6/19/25 at 12:19 p.m., in a telephone interview CNA Staff G said she was assigned to Resident #48 on 5/1/24 from 7:00 a.m. to 7:00 p.m. She said CNA Staff U assisted her to transfer Resident #48 with the manual sit-to-stand lift. She said Resident #48 was totally dependent on staff for everything. Staff G said, "She cannot turn, reposition herself or assist with the transfer with the (brand name sit-to-stand lift). CNA Staff G said it takes 2 staff to hold the resident by her pants and lift her to place her in the lift. She said Resident #48 cannot assist with the transfer with the lift, she is not even able to place her hands on the handlebar and cannot sustain her weight. Staff has to make all the effort to get her in the lift. CNA Staff G said after the incident someone must have realized the resident was not appropriate to use the lift and they changed it to a full body mechanical lift. She said for some reason, they went back to the manual sit-to-stand lift. CNA Staff G said she did not remember Resident #48 complaining about her foot with the transfer. When asked if she notified her supervisor of the difficulty Resident #48 had with the use of the manual sit-to-stand lift, she said she did not. On 6/19/25 attempted to contact CNA Staff U via telephone and got an error message. On 6/19/25 at 1:40 p.m., in a telephone interview LPN Staff O said on 5/2/25 Resident #48 was crying and was in a lot of pain. Her left foot was swollen and bruised. The resident said the CNAs used the lift wrong the previous evening and hurt her foot. She said she immediately reported it to the evening supervisor, Registered Nurse (RN) Staff D who instructed her to call the physician. LPN Staff O said she did not think she had to write an incident report since the incident	N0201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11120951	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N0201 SS = K	Continued from page 11 did not happen on her shift. On 6/19/25 at 2:58 p.m., a joint interview was held with the DON and the evening supervisor, RN Staff D. RN Staff D verified on 5/2/25 LPN Staff O told her about Resident #48's bruised and swollen left foot but did not tell her how the resident sustained the injury. She instructed LPN Staff O to call the resident's attending physician. Evening supervisor RN Staff D said she knew she was supposed to assess the resident but she already had her bag on her shoulder and was leaving. The DON said the expectation was for the evening supervisor, RN Staff D to go assess the resident and give directions to the LPN. Review of the personnel files for CNAs Staff C (date of hire 1/30/2008), Staff W (date of hire 3/12/2001), Staff S (Date of hire 3/4/2025) and Staff Y (Date of hire 4/1/25) failed to reveal documentation of training, in-service or competency evaluations on use of manual and mechanical lifts. On 6/21/25 at 1:40 p.m., CNA Staff W and CNA Staff X were observed transferring Resident #33 with a (brand name) full body mechanical lift. The Assistant Director of Nursing (ADON) was in the room observing the transfer. The sling was worn out and the label was missing. Two holes were observed in the sling's fabric. The sling straps showed signs of damage and were frayed. "Photographic evidence obtained." On 6/21/25 at 1:50 p.m., the ADON observed the holes in the sling's fabric and verified the sling was worn out and the label was missing. She also verified the straps showed signs of damage and were frayed. The ADON offered no explanation for the continued use of the worn out sling. Review of the manufacturer's manual for use of the slings provided by a representative of the sling's manufacturer revealed, " Before every use, WARNING. To avoid injury, always make sure to inspect the equipment prior to use. Check all parts of the sling . . . If any part is missing or damaged- Do NOT use the sling. Check	N0201		

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N0201 SS = K	Continued from page 12 for: Fraying, loose stitching, tears, fabric holes, soiled fabric, damaged clips, unreadable or damaged label. . ." Review of the facility's policy and procedure titled "Lifting Machine, Using a Mechanical" with a revised date of July 2017 revealed, "The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. . . Sling care: discard any worn, frayed or ripped slings. . ." Class I	N0201		