DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	R 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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{F 000}	INITIAL COMMENTS An onsite revisit survey was conducted on 9/25/23 for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities for all previous deficiencies cited on 8/24/23. Winner Regional Healthcare Center was found not in compliance with the following requirements: F684, F688, F689.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on plan of correction review, record review, policy review, interview, and observations, the provider failed to follow their amended 9/21/23 plan of correction for three of three sampled residents (8, 9, and 27) to ensure: *Resident skin assessments had been completed by a registered nurse (RN) as indicated in the provider's plan of correction. *The director of nursing (DON) B had implemented an effective weekly audit tool to ensure resident skin assessments had been completed and identified concerns addressed appropriately. Findings include: 1. Review of the providers 9/21/23 updated plan	{F 684}	F684 – Quality of Care The Weekly Nursing Skin Checks Policy has been updated to reflect the new process as identified in the Plan of Correction effective 2 October 2023. As stated in the revised Weekly Nursing Skin Checks policy a skin audit will be conducted on the first bath day of the week for each resident and charted in the Skin Observation portion of Point Click Care. The nurse performing the skin audit will be responsible for documenting on prior skin audits findings including charting on blanched or non-blanched, measurements of new or previously identified skin bruises and tears, pain/ soreness reported by resident, temperature of skin, moisture of skin, skin, turgor, and lesion/skin breakdown. The documentation of the skin audits will continue for each skin issue until the skin issue is resolved and documented that the issue is resolved. The DON/designee will audit three patients a week to verify skin audit findings.	October 2 2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 10/16/23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 684}	Continued From page 1 of correction and documention on their statement of deficiencies revealed: *"The RN on duty will have performed a complete skin assessment on all residents by September 21, 2023, and the DON will verify the charting on the skin assessments are completed and addressed appropriately. The nurse on duty will complete a skin assessment on all residents during their first bath of the week and the DON conducts a weekly audit to ensure all residents skin assessments are completed and addressed." *A request for residents with non-pressure related skin injuries revealed two residents (8 and 9) had skin bruises identified since the recertification survey on 8/24/23. *Review of the DON's weekly audit tool titled "24 Hour Chart Checks 2021" revealed a previously prepared 2021 form to be used for each individual resident that included a column for a checkmark. -A checkmark indicated a skin observation was completed on bath day. *Review of the provider's education provided to staff regarding the quality of care and skin observation revealed: -An agenda for review of the plan of correction dated September 13th, 2023, and September 21st, 2023, was provided. -The agenda documented "Skin observations will be conducted on all residents during each bath time. Nursing staff will document any wounds/bruises identified during the assessment or during any type of care. The findings of these assessments will be charted in the resident's chart." 2. Review of resident 8's medical record revealed: *A skin observation entry dated 9/19/23 was in	{F 684}	An audit tool will be used to document completed skin audits and presented to the QAPI committee for a period of 12 months. Resident 8 did have a skin assessment on September 26, 2023, resident 9 received a full skin assessment on October 2, 2023, and again on October 3, 2023. Resident 27 received a full skin assessment on October 2, 2023. All three of these assessments were documented in the skin observation portion of PCC.	

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{F 684}	Continued From page 2 the assessment section in the medical record. -The skin observation form documented "skin clear/intact" in the notes section of the document. *A health status note dated 9/21/23 was in the progress notes section of the medical record. -The health status note documented "Resident has multiple discoloration to her lower extremities. Noted big purple bruise to her left inner thigh, and right outer thigh. Her left shin swollen, appeared yellow, dark, and warm to touch. *A second health status note dated 9/21/23 documented "Left shin yellowish dark, swollen, and warmth when the area is touched. No fever noted. [Physician] notified via fax. *Two hospice progress notes dated 9/21/23 where the hospice nurse evaluated the resident and documented "the left knee is slightly warmer than the rest of her legs.", "Hospice nurse called, and she has not heard anything back from [the physician] on how she wants to treat her left knee area. Will continue to monitor and keep her comfortable as much as possible." And "Recorder did tell [hospice nurse] that family needs to be notified about the bruises and she told recorder she would update [family]." *A hospice progress note dated 9/22/23 documented "pain noted throughout the night. LLE [left lower extremity] swollen and warm. Will continue to monitor." *A hospice progress note dated 9/23/23 documented "LLE [left lower extremity] remains swollen and warm. *There was no further documentation in the medical record regarding the multiple discolorations to her lower extremity had been addressed or if there was any follow up with the physician.	{F 684}	**F684 10-12-2023** As identified in a previous Plan of Correction the DON performed a full skin audit on every resident prior to September 21, 2023, to evaluate any resident that may have been affected by uncompleted skin observations. Since this time skin observations have been occurring during the first bath of the week for each resident. Since September 26, 2023, the skin observations have been documented in the Skin Observation portion of PCC under the Assessment Tab. The DON/designee is reviewing these observations on a weekly basis and monitoring the follow-up on skin issues through resolution. The monitoring of the skin observations will continue weekly for 6 months and reported to QAPI monthly, after the 6 months the observation will continue on a weekly basis with 3 residents skin observations being reviewed weekly by the DON/designee for an additional six months and report to QAPI monthly.	

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{F 684}	Continued From page 3 Observation on 9/25/23 at 4:55 p.m. of resident 8 in her wheelchair at the nurse's station attempting to independently propel her wheelchair with her feet revealed: *She was clothed, and her lower extremities were not visible. *Her left hand and the top of her left lower arm had several red and purple scattered bruises. 3. Review of resident 9's medical record revealed: *A skin observation entry dated 9/18/23 was in the assessment section in the medical record. -The skin observation form documented in the notes section "skin clear/intact" and "9/21/23 updated this resident had a bath this morning and has 2 new bruises one on her RFA [right forearm] and 1 on her right wrist, she doesn't know how this happened, "I just woke up with it." *An incident note dated 9/21/23 was in the progress notes section of the medical record. -The incident note documented "Superficial bruise 4.5 cm x 0.2 cm linear purple in color on anterior RFA [right forearm] and a 0.3 cm x 0.3 cm circular bruise on middle right wrist area." *There was no further documentation in the medical record if the resident's bruising of unknown origin was addressed by the nursing staff. Observation on 9/25/23 at 5:09 p.m. of resident 9 at the dining room table in her wheelchair revealed: *She was waiting for dinner to have been served. *She required assistance from staff for meals. *She had three small red bruises located on the top of her right hand, and lower arm. 4. Review of resident 27's medical record	{F 684}		

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{F 684}	Continued From page 4 revealed: *Skin observation assessment dated 9/11/23 documented in the notes section "skin clear/intact with numerous stages bruising arms/dorsal hands." *Skin observation assessment dated 9/18/23 documented in the notes section "skin clear/intact." Observation on 9/25/23 at 5:00 p.m. of resident 27 in the dining room revealed: *A dark bruise covering three-fourths of the top left hand and the right arm and forearm had multiple faded bruises. 5. Review of the provider's Weekly Nursing Skin Checks policy dated 3/1/12 revealed: *The most recent policy reviewed date was 2/2020. *"3. The licensed nurse will complete a head-to-toe assessment of the resident's skin and document by notation any alterations of the skin condition on the body audit sheet. *4. The licensed nurse will then follow-up on any new skin issues and proceeds with appropriate notification to physician and family and implement any care needed." *5. The nurse will document her findings in the resident chart and document on the 24 hour report. *6. The resident care plan will be updated as needed." Interview on 9/25/23 at 3:30 p.m. and again at 4:30 p.m. with DON B revealed: *The provider's process for skin assessments was the nurses were to assess every resident's skin once weekly during their first scheduled bath of the week and document their findings and any	{F 684}		

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{F 684}	Continued From page 5 interventions on the skin observation assessment form in the resident's electronic medical record. *The providers provider's policy was not updated to reflect the process identified in the updated plan of correction dated 9/21/23, she had not thought of that and asked if that would have been a good idea. *Her audit tool was a form for each resident that included a column for a checkmark and was titled "24 Hour Chart Checks 2021." *Her process for audits was to look in the chart and confirm there was a skin observation assessment completed weekly on the bath days for each resident. *She was not opening the skin observation form to review if the assessments were completed or if skin concerns were identified or followed up on appropriately. *She agreed the record reviews completed for resident's 8, 9, and 27 had not met the plan of corrections interventions to ensure the nurse on duty completed a skin assessment and addressed identified skin concerns appropriately. *She agreed when the nurses documented in the skin observation assessment form, they were skipping the observations body audit section which required a wound site, type and measurements. The documentation was only included in the notes section and was incomplete. *She agreed that her audits -Did not meet the plan of corrections intervention to ensure skin assessments were completed and addressed appropriately. -Her current completed audits missed that nurses were not consistently documenting in the skin observation assessment but were documenting identified skin concerns in several other places in the electronic medical record and were not documenting that skin concerns were addressed	{F 684}		

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{F 684}	Continued From page 6 appropriately. -The documentation inconsistencies could have led to problems with nurses reviewing the medical record to identify if observed skin concerns or wounds were new or previously identified, follow-up had been missed, or wounds that were improving, not healing, or getting worse.	{F 684}		
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, plan of correction review, education review, and record review, the provider failed to implement their plan of correction to ensure seven of seven sampled residents (6, 12, 17, 21, 24, 27, and 29) had received restorative nursing services out of 28 residents who required restorative nursing services. Findings include:	{F 688}	F688 – Increase/Prevent Decrease in ROM/Mobility A restorative CNA started on October 1, 2023, and began the restorative program on October 4, 2023. The restorative CNA performed restorative care on five residents and will increase five residents a day for restorative care. The residents receiving restorative care are being charted in the progress notes section of PCC along with restorative section of the plan of care. Restorative Care will be provided to residents 5 days a week and will be working with the therapy department to identify and follow up with the residents on this program. In addition, CNA's will be documenting in the task portion of the residents records restorative programs such as walk to dine. Resident 27 received restorative care on 5 October 2023 and the notes have been documented in the resident's chart. Resident 12 received restorative care on 5 October 2023 and the notes have been documented in the resident's chart. Resident 21 received restorative care on 5 October 2023 and the notes have been documented in the resident's chart.	October 4 2023

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{F 688}	Continued From page 7 1. Interview on 9/25/23 at 12:07 p.m. with director of nursing (DON) B revealed: *The certified nursing assistant (CNA) that was identified in the plan of correction as starting on 9/20/23 for restorative care had "already quit." *The "chart reviews to ensure restorative care is occurring on residents who are care planned for this care," as stated on the plan of correction, had not yet started. *Education had been provided to the current CNAs about documenting the restorative activities that they were assigned to complete. Interview on 9/25/23 at 2:30 p.m. with director of rehab W revealed: *The therapy department had developed two lists for DON B of the residents who needed restorative nursing services. *One list displayed twenty residents' restorative needs sorted by wings. *The other list displayed eight residents who needed "maintenance services" to prevent decline. *Some restorative services could have been provided by the shift CNAs but the services that required more skill and equipment needed to be provided by a restorative CNA (RNA). Interview on 9/25/23 at 4:30 p.m. with DON B revealed she: *Could not explain the difference between the two lists that had been provided by the therapy department. *Was not familiar with how to use Point Click Care, the electronic medical record (EMR) software, to modify restorative assignments to include all CNAs in addition to or as a back-up to the RNA assignments. *Had not shared the provider's "Restorative	{F 688}	Resident 24 received restorative care on 5 October 2023 and the notes have been documented in the resident's chart. Resident 29 refused restorative care on 5 October 2023 and the notes have been documented in the resident's chart. The restorative program will be monitored by the DON/Designee on a weekly basis and the report will be presented in the monthly QAPI meeting for a period of 6 months.	

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{F 688}	Continued From page 8 Nursing Policy," reviewed on 02/2020, with the staff during the education meetings. Review of the "Agenda for review of Plan of Corrections 2023" revealed: *Staff education occurred on 9/13/23 at 2:00 p.m. and 9/21/23 at 4:30 p.m. *The education provided for tag F688 included: -"The restorative CNA will work with the DON and therapy department regarding restorative care." -"The DON or designee will review with the restorative care CNA weekly the residents and their progress." 2. Review of the "look back" documentation between 8/26/23 and 9/24/23 for maintenance restorative tasks for three residents (6, 17, and 21) on the "maintenance services" list revealed: *No documentation was displayed, which indicated the task had not been completed, or *There was a minimal frequency of completed documentation, or *There was no link available to display the documentation, as follows: *Resident 6's "look back" documentation included: -No data displayed for "MAINTENANCE - Transfers - sit to stand with hand held assist x [times] 10 reps [repetitions], cues to scoot forward, bend knees and lean forward to assist with transfers," started on 12/31/19, assigned to RNA. -"MAINTENANCE: (Splinting program) Resting hand splint to be used when she is napping during the day and for up to 6 hours at night...Do ROM [range of motion] to stretch hand before putting the splint on," started on 3/11/22, assigned to CNAs every shift, displayed:	{F 688}	**F688 10-12-2023** The residents on the restorative program had been reviewed and reassessed with edits to the program as needed by the therapy department. Due to a misunderstanding with the therapy department the residents identified in the Plan of Correction did not start their restorative program until October 5, 2023. The Restorative CNA did however start seeing residents for restorative care on October 4, 2023. In PCC the DON/Designee monitors the completed restorative Plan Of Care and restorative progress notes in the Progress Note section of PCC. The DON/Designee will monitor 10 residents weekly for six months, then they will monitor 10 residents per month for an additional six months. The reports will be presented to the QAPI committee monthly.	

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{F 688}	Continued From page 9 --One day, 9/6/23 at 11:39 p.m., as "Splint On." --One day, 8/29/23 at 3:10 a.m., as "Resident Refused." --26 days as "Splint Off." *Resident 17's "look back" documentation included: -No data was displayed for two tasks started on 2/3/21, assigned to RNA: --"MAINTENANCE - Transfer Program - sit to stand transfers or stand pivot transfers as tolerated." --"MAINTENANCE - Walking Program - ambulate as tolerated with hand held assist." -No link was available to display documentation for "Primary mobility is per wheel chair, but assist to ambulate as she desires, use gait belt and allow her to hold your hand," started on 4/20/21, assigned to CNA. *Resident 21's "look back" documentation included: -No link was available to display documentation for "Can ambulate short distances with walker, gait belt and one assistant, prefers not to," started on 5/26/21, assigned to CNA, physical therapy (PT) and PT assistant. -No data was displayed for three tasks started on 5/18/23, assigned to RNA: --"MAINTENACE [sic] - Range of Motion - - Seated leg exercises...Standing leg exercises...Supine leg exercises...NuStep." --"MAINTENANCE - Transfer Program - Sit to stand transfers at railing x 10-15 reps." --"MAINTENANCE - Walking Program - Ambulate with 4WW [four wheeled walker] x 20-90 ft [feet] with assist as needed." 3. Review of the "look back" documentation	{F 688}		

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{F 688}	Continued From page 10 between 8/26/23 and 9/24/23 for restorative tasks for four residents (12, 24, 27, and 29) on the list divided by wings revealed: *No documentation was displayed, which indicated the task had not been completed, or *There was a minimal frequency of completed documentation, or *There was no link available to display the documentation, as follows: *Resident 12's "look back" documentation included: -No data was displayed for "RESTORATIVE - Transfer Program - sit to stand or stand pivot transfer with cues as needed," started on 10/14/20, assigned to RNA. -No data was displayed for "RESTORATIVE Range of Motion - Active assistive ROM using L [left] UE [upper extremity] to move R [right] UE," started on 3/29/22, assigned to RNA. -No data was displayed for "RESTORATIVE: Walk to Dine/Ambulation Walk with 2WW [two wheeled walker] as tolerated, follow with WC [wheelchair], started on 3/29/22, assigned to CNA. -"IN ADDITION TO RESTORATIVE: Walk to the dining room and back to his room with walker, gait belt and one assist, follow with his wheel chair so he can sit down when he tires," started on 3/29/22, assigned to CNA, displayed the task had been completed on 16 days. *Resident 24's "look back" documentation included: -No data was displayed for two tasks started on 3/2/22, assigned to RNA: --"RESTORATIVE - Range of Motion - active, active assist or passive range of motion to all joints in bilateral upper extremities and lower	{F 688}		

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{F 688}	Continued From page 11 extremities as tolerated." --"RESTORATIVE - Dining - resident is right handed. scoop food onto utensil and then place in residents right hand. hand over hand assist with self feeding as needed. assistance to lift right upper extremity by lifting her elbow is more effective." -No data was displayed for "RESTORATIVE: Splint/Brace Assistance (Left Hand) Wear PRN [as needed] AM [morning] & PM [afternoon]," started on 3/2/22, assigned to RNA and CNA. *Resident 27's "look back" documentation included: -No data was displayed for two tasks started on 11/10/22, assigned to RNA: --"RESTORATIVE: Range of Motion - NuStep for LE and UE strengthening as tolerated. Seated upper extremity and lower extremity exercises x 10-20 reps as tolerated." --"RESTORATIVE: Transfers - Sit to stand or stand pivot transfers with assistance as needed. Complete 10 reps or as tolerated at 2WW or wall railing. -No data was displayed for "RESTORATIVE: Walking - Ambulate with 2WW and CGA [contact guard assist], follow with wheelchair for safety," started on 11/10/22, assigned to CNA and RNA. *Resident 29's "look back" documentation included: -No data was displayed for two tasks started on 6/26/23, assigned to RNA: --"RESTORATIVE: Transfer Program - sit to stand at wall railing as tolerated. Sit to stand in Sara Steady, cues as needed for safety during all transfers. --"RESTORATIVE: ROM Program - balloon volley, ball toss, ball kick, NuStep, LE exercises,	{F 688}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	R 09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 688}	Continued From page 12 UE exercises as tolerated."	{F 688}		
{F 689} SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, plan of correction review, and education review, the provider failed to implement their plan of correction to ensure staff used foot pedals when propelling one of one randomly sampled resident (12) in the wheelchair to the dining room. Findings include: 1. Observation and interview on 9/25/23 at 11:50 a.m. revealed: *Certified nursing assistant (CNA) V propelled resident 12 in his wheelchair into the dining room. *Resident 12 had his feet lifted off the floor as the wheelchair was pushed forward. *There were no foot pedals attached to the wheelchair. *Resident 12 directed CNA V to the correct table where he sat for mealtimes. *When asked about the foot pedals, CNA V explained they were not in the bag on the back of resident 12's wheelchair. Review of the 8/8/23 annual Minimum Data Set for resident 12 revealed:	{F 689}	F689 – Free of Accident Hazards/ Supervision/Devices On September 25, 2023, all the residents have been equipped with bags for holding wheelchair pedals for each resident who has been identified as able to self-propel. The pedals have been verified as the right fit with the therapy department and if they are not being used staff has been educated to place them in the bag on the resident's wheelchair. The Nursing Home Administrator/Designee will continue to monitor the use of wheelchair pedals during transportation to and from the dining room for meals. This observation will occur for seven meals per calendar week for a period of one month, after which the administrator/ designee will continue the observations for ten meals during the next five months. The Wheelchair observation audit tool will be presented to the QAPI Committee for a period of six months. The state surveyors identified that Employee V was propelling Resident 12 without pedals on the wheelchair. On September 25, 2023, the DON re-educated employee V concerning using wheelchair pedals on residents who request or need to be propelled to and from locations. The pedals for resident 12 were in the corner of the resident's room and placed in the resident's pedal bag on the wheelchair. Resident was educated that staff will no longer be able to	October 4 2023

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{F 689}	Continued From page 13 *His Brief Interview for Mental Status (BIMS) score was 15 indicating he had no cognitive impairment. *He had no lower extremity impairments. *He needed the extensive assistance of one person for moving between locations on the unit and off the unit. Review of the care plan for resident 12 revealed a goal revised on 9/19/23 for "independent wheel chair mobility most of the time and be able to walk most of the way to one meal a day." Interview on 9/25/23 at 2:30 p.m. with director of rehab W revealed: *The therapy department had helped the nursing staff with an inventory of wheelchair foot pedals for all residents. *There were five residents for whom they had needed to obtain different foot pedals. *She could not recall which residents those were. Review of the "Nursing Home Resident Tracking List" provided by director of nursing (DON) B revealed: *A list of all residents that indicated if the resident was "self-propel (manual)," "dependent manual," or "power wheelchair." *Resident 12 was checked as self-propel and was one of five residents that had "No" marked in the column labeled "Pedals." Interview on 9/25/23 at 5:20 p.m. with DON B revealed: *Resident 12 had needed different foot pedals for his wheelchair. *CNA V had been educated on the use of foot pedals when propelling a resident in a wheelchair. *The tracking list was just completed.	{F 689}	assist residents in propelling them unless the wheelchair pedals are in place even if requested to do so without the pedals in place. The MDS for Resident 12 has been reviewed and updated by the MDS company. The Administrator/Designee will continue to educate at daily huddle that all residents must have wheelchair pedals for 15 of the 31 days in October.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 689}	Continued From page 14 *They wanted that list completed before they had started to conduct monitoring audits. *Audits had not yet started as outlined in the plan of correction: "The Administrator will monitor the use of pedals during mealtime travel to and from the dining hall at 7 meals a week for 1 month and then for 5 months the Administrator will monitor during the same timeframe for 10 meals a month." Review of the "Agenda for review of Plan of Corrections 2023" revealed: *Staff education occurred on 9/13/23 at 2:00 p.m. and 9/21/23 at 4:30 p.m. *The education provided for tag F689 included: -"Residents will have wheelchair bags for pedals to be placed into." -"Occupational Therapy when assessing the individuals for appropriate wheelchair will also assess for correct wheelchair pedals. If individual is self-propelled [,] pedals will be placed in the pedal bag." -"When patients are being transported via wheelchair, foot pedals must be in place and utilized." Review of staff signatures for the staff education on 9/21/23 revealed CNA V had attended on that day.	{F 689}		