STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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
E 000	Initial Comments An unannounced Emergency Preparedness Focused Survey was conducted onsite 01/12/2021 and continued with offsite review through 01/19/2021. On 01/14/2021 the COVID-19 portion of the survey was added. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced abbreviated Medicare/Medicaid survey was conducted onsite 01/12/2021 and continued with offsite review through 01/19/2021. On 01/14/2021 a COVID-19 Focused survey was added. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. Three complaints were investigated during the survey. All three complaints were unsubstantiated. The census in this 142 certified bed facility was 87 at the time of survey. During the onsite portion of the survey 12 residents and 10 staff were positive for COVID-19. On 01/14/2021 when the Focused COVID-19 portion of the survey was added 16 Residents and 8 staff were positive for COVID-19.	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	F 684		2/18/21

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

Electronically Signed | 02/10/2021

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F 684	Continued From page 1 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 staff interview and clinical record review, the facility staff failed to ensure the resident received the ordered treatment for 1 of 7 residents, Resident #3. The findings included: The facility staff failed to administer Resident #3's physician ordered Lasix for 3 days. The resident only received the new dose for 2 days. The EHR (electronic health record) included the diagnoses, chronic obstructive pulmonary disease, respiratory failure, and shortness of breath. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/07/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The residents comprehensive care plan included the focus areas at risk for respiratory distress has the diagnoses of chronic obstructive pulmonary disease, respiratory failure, shortness of breath, history of upper respiratory illness, history of pneumonia. Interventions included, administer medications as ordered. The residents EHR (electronic health record)	F 684	F684 This plan of correction is being submitted in compliance with specific regulatory requirements, and preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction for 684. 1.Re-education on proper administration and prevention of inaccurate entry or omissions to the clinical records. 2.Residents throughout the building had the potential to be affected by this. Four residents on each unit will have their administration record audited for missing medication on the MAR or TAR. 3.Licensed staff were re-educated by DON/ designee regarding the appropriate documentation of medications given on the narcotic sheets, MAR, and residents note section for any unusual variance. 4.DON / designee will do an audit of missing medications weekly for four weeks to ensure continued compliance and re-educate as needed. Results will be	

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F 684	Continued From page 2 included a physicians order dated 12/31/2020 to administer 40 mg of Lasix by mouth in the morning related to acute diastolic congestive heart failure for 3 days. A review of the residents EMARS (electronic medication administration records) for 12/2020 and 01/2021 revealed that Resident #3 was administered this medication on 12/31/20 and 01/01/21. There was an "X" in the medication box beside this medication for 01/02/21. Indicating the resident only received 2 doses of this medication and not 3 as ordered. On 01/14/2021 at 9:38 a.m., the interim DON (director of nursing) was made aware of the issue regarding the residents Lasix order. On 01/15/2021 the interim DON verbalized to the surveyor that they had spoken with the nurse who entered this order into the EHR and it appeared that due to the way the order was entered Resident #3 did not receive their third dose of Lasix. The interim DON verbalized to the surveyor that they would be re-educating the staff on this issue. No further information regarding this issue was provided to the surveyor prior to the exit conference.	F 684	discussed in QAPI.	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance	F 687		2/18/21

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F 687	Continued From page 3 with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide a physician ordered treatment to the residents left foot for 1 of 7 residents, Resident #7. The findings included: The facility staff failed to provide a physician ordered treatment to Resident #7's left foot toe surgical wound. Resident #7 had been discharged from the facility. This was a closed record review. Resident #7's clinical record included the diagnoses, cellulitis of left toe, osteomyelitis left ankle and foot, peripheral vascular disease, diabetes, and acquired absence of other left toe(s). Section C (cognitive patterns) of the residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/28/2020 included a BIMS (brief interview for mental status) summary score of 14 out of a possible 15 points. Section M (skin conditions) was coded to indicate the resident had a surgical wound and was receiving surgical wound care. Resident #7's comprehensive care plan included	F 687	f687 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction for 687. 1.Quality of care will be assessed in regards to accurate order entry when residents are admitted and when new orders are obtained. 2.Residents throughout the building had the potential to be affected by this. Admissions from the last two weeks were reviewed to ensure that the admission orders matched the discharge summary. 3.Licensed staff were re-educated by DON/ designee regarding process for entering orders that have time parameters as well as double check progress for new admissions. 4.DON or designee will do a weekly audit on new orders and new admissions for weeks to ensure continued compliance and re-educate as needed. Results will be discussed in QAPI.	

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F 687	Continued From page 4	F 687		

the focus areas, altered skin integrity non-pressure related to left 2nd toe surgical wound and I have a surgical wound. Interventions included treatments as ordered.

A review of the residents "Admission Data Collection Form" completed 08/21/2020. Revealed that Resident #7 had been admitted to the facility with a stage 1 pressure ulcer to their left buttock and a left second toe amputation surgical wound that measured 4.5 X 3 X 2. Under skin treatments that facility nursing staff had documented that the resident would be receiving surgical wound care. LPN (licensed practical nurse) #1 had completed this form. LPN #1 was identified by the facility as no longer being an employee at this facility.

The residents "TRANSFER SUMMARY" from a local hospital dated 08/20/20 indicated Resident #7 had recently had their 2nd left toe amputated and was being discharged to a long term care facility. This transfer summary included the following documentation. Continue taking these medications silver sulfadiazine topically daily. Start taking the following new medications Sodium hypochlorite (dakin's 1/2 strength solution) daily. The last page of this document included the documentation "Wound Care" Apply 4X4 gauze soaked in 0.25% Dakin's solution once daily and wrap in Kerlix and Ace. Under "Special Instructions", this document read in part, "...Please follow wound care instructions as outlined above..."

When reviewing the residents EMARs (electronic medication administration records) and the residents ETARS (electronic treatment administration records) for 08/2020 the surveyor

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F 687	Continued From page 5	F 687		

was unable to locate any information for either of these treatments. A review of these documents for 09/2020 revealed that the facility had documented they had applied the dakins solution on 09/02/2020 to the residents left foot surgical site. On 09/03/2020, the nurse documented a "3" for hold see nurses note.

On 09/03/2020 RN (registered nurse) #3 documented the following, "Rsd (resident) left this am at 8am via facility transport, and returned with order to d/c (discontinue) current tx (treatment) to left foot and keep drsg (dressing) intact and f/u (follow-up) appt (appointment) 8/10/20 (sic) at 8:20am. rsd notified of new orders."

The clinical record included a progress note transcribed by the certified nurse practitioner with a date of service of 08/21/2020. This progress note included documentation to indicate the resident was receiving "Sodium hydrochloride Dakin solution applied to left foot wound, and continue with wound care as identified by wound care clinic." There was no documentation in reference to the silver sulfadiazine.

A review of the resident's wound measurements revealed that on 08/28/2020 that facility staff documented that the residents wound had improved and measured 4 X 2.5 X 2. On 09/04/2020 and 09/11/2020, the facility staff documented that the wound had improved and measured 4 X 2.3 X 2. On 09/25/2020, the facility staff documented that this area had healed.

This resident was discharged to home on 09/28/2020.

On 01/15/2021 at 11:40 a.m., the interim DON

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F 687	Continued From page 6 (director of nursing) verbalized to the surveyor that they had reviewed the residents clinical record and was unable to confirm as to why the dakins solution and silver sulfadiazine were not on the residents treatment orders. No further information regarding this issue was provided to the surveyor prior to the exit conference.	F 687		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		2/18/21

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F 842	Continued From page 7 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842		

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F 842	Continued From page 8 Based on resident interview, staff interview, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 7 residents, Resident #3. The findings included: The facility staff failed to document for the administration of Resident #3's Xanax, Trazadone, and Oxycodone. The EHR (electronic health record) included the diagnoses, anxiety disorder, chronic obstructive pulmonary disease, respiratory failure, and shortness of breath. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/07/2020 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The residents EHR (electronic health record) included the following physician orders: Xanax 1 mg give 1 mg at bedtime related to anxiety disorder. Trazadone 100 mg give 1 tablet at bedtime related to major depressive disorder. Oxycodone 5 mg give 5 mg three times a day for pain. A review of the residents EMARS (electronic medication administration records) revealed that the facility nursing staff had not documented that the Xanax, Trazadone, or Oxycodone had been administered on 01/01/2021 at 2200 (10 p.m.) or for the Oxycodone on 01/11/2021 at 2200 (10 p.m.).	F 842	F 842 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction for 842. 1.Re-education on proper administration and prevention of inaccurate entry or omissions to the clinical records. 2.Residents throughout the building had the potential to be affected by this. Four residents on each unit will have their administration record audited and matched back to ensure the medication administration is documented appropriately. 3.Licensed staff were re-educated by DON/ designee regarding the appropriate documentation of medications given on the narcotic sheets, MAR and residents note section for any unusual variance. 4.DON/ designee will do an MAR to cart to paper narcotic log weekly for four weeks to ensure continued compliance and re-educate as needed. Results will be discussed in QAPI.	

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F 842	Continued From page 9 On 01/12/2021 at 11:24 a.m., during an interview with Resident #3, this resident verbalized to the surveyor that they knew their medications and did not state that they had missed any medications. On 01/14/2021 at 9:38 a.m., the interim DON (director of nursing) was made aware of the missing documentation. The facility provided the surveyor with a copy of the residents narcotic count sheet for the Xanax and Oxycodone. A review of narcotic count sheets revealed that the nurse had documented that they had removed one Xanax and one Oxycodone for the 10 p.m. doses on 01/01/2021 and one Oxycodone on 01/11/2021 for the 10 p.m. dose. The administrator and interim DON were made aware of the missing documentation on 01/19/2021 at approximately 3:45 p.m.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		2/18/21

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F 880	Continued From page 10 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and the review of documents, it was determined the facility staff failed to properly implement COVID-19 prevention and/or control measures for a LPN (licensed practical nurse). The findings included: LPN (licensed practical nurse) #2 removed their facemask and face shield while speaking with the surveyor and was observed with their facemask to be positioned underneath their nose. During initial tour of the facility on 01/12/2021, and while standing in the hallway on the south unit, LPN #2 was observed with only one strap on their N95 mask positioned behind their head. LPN #2 verbalized to the surveyor that their mask was too tight with both straps and proceeded to remove their mask and their face shield to reposition the straps. This was on the non COVID-19 unit. At approximately 10:20 a.m., LPN #2 was observed in the hallway near the south unit	F 880	F 880 To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction for 880. 1.Re-education on proper PPE and continued monitoring of staff use of PPE. 2.Residents throughout the building had the potential to be affected by this. Random spot checks of staff were conducted on all shifts to reinforce the importance of use of appropriate PPE. 3.Licensed staff were re-educated by DON/ designee regarding PPE use and disciplinary actions for lack of appropriate use. 4.Leadership will do unannounced rounds on every weekly for four weeks to ensure continued compliance and re-educate as needed. Results will be discussed in QAPI.	

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F 880	Continued From page 12	F 880		

nurses station with their facemask positioned below their nose. The surveyor stated to LPN #2 that their mask needed to be up over their nose LPN #2 verbalized to the surveyor that they knew the seriousness of COVID-19. This was on the non COVID-19 unit.

On 01/14/2021 at 9:20 a.m., during a phone interview with LPN #9, this nurse was asked what kind of PPE the staff on the non COVID-19 units were wearing. This staff verbalized to the surveyor that the staff were wearing a N95 mask, face shield, and a gown at all times and when they entered a room, they would wear gloves.

On 01/15/2021 at 11:40 a.m., the interim DON (director of nursing) was notified of the issue regarding LPN #2 removing their mask and face shield and their mask being positioned under their nose.

A review of LPN #2's daily screening completed on 01/12/2021 revealed that this staff's temperature was 97.4 and they denied any recent exposure or symptoms in regards to COVID-19.

The facility provided the surveyor with LPN's last COVID-19 test completed at the facility. This test was completed on 01/07/2021 and was negative. The facility also provided the surveyor with a copy of LPN #2's education sign-up sheet regarding PPE (personal protective equipment). LPN #2 and other staff members had signed it but it did not include a date.

The facility provided the surveyor with a copy of a document titled, Donning (putting on the gear). This document read in part, Facemask: Mask ties should be secured on crown of head (top tie) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	A. BUILDING _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTINSVILLE HEALTH AND REHAB	1607 SPRUCE STREET MARTINSVILLE, VA 24112

(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
F 880	Continued From page 13 base of neck (bottom tie). On 01/15/2021 at 11:49 a.m., the interim DON (director of nursing) designated IP (infection preventionist) verbalized to the surveyor that all of the facility staff wore N95 masks. The interim DON was notified that LPN #2 had been observed by the surveyor with one strap of their N95 not in place, observed removing their N95 facemask and face shield, and observed with their N95 mask positioned down below their nose. During the exit conference on 01/19/2021 the interim DON (designated IP) verbalized to the surveyor that was not an appropriate way to wear PPE. No further information regarding this issue was provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		2/18/21

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F 883	Continued From page 14 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review,	F 883	F 883	

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F 883	Continued From page 15 and facility document review, the facility staff failed to determine if the resident had the opportunity to receive or refused the pneumonia vaccine for 1 of 7 residents, Resident #2. The findings included: For Resident #2, the facility staff failed to determine if the resident consented or declined the pneumonia vaccine. The area for the resident to decline or accept the vaccine had been left blank on the consent form. Resident #2's EHR (electronic health record) included the following diagnoses, asthma, chronic kidney disease and depressive disorder. Section C (cognitive patterns) of the residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/06/2020 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points. Section O (special treatments and programs) had been coded to indicate the resident had been offered and declined the pneumonia vaccine. The facility provided the surveyor with a copy of the residents "CONSENT FORM INFLUENZA VACCINE AND PNEUMOCOCCAL CONJUGATE VACCINE." For the influenza vaccine, the area marked "This Resident DOES wish to receive the Inactive Influenza Vaccine" included the Residents name. The signature line had been left blank. The Resident received the flu vaccine on 10/14/2020. For the pneumonia vaccine, the areas for accepting or declining the vaccine had not been marked. The bottom of this form included Resident #2's initials it did not include a	F 883	To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction for F883. 1. Influenza and pneumonia vaccine will be offered upon admission to all residents and documented appropriately. 2. Residents throughout the building had the potential to be affected by this. A review of current vaccination status was completed and residents were evaluated and ensured to have an active consent or declination on file. 3. Licensed staff were re-educated by DON/ designee regarding immunization compliance. 4. Unit Managers or designee will do a weekly audit of new admissions for 4 weeks to ensure continued compliance and re-educate as needed. Results will be discussed in QAPI.	

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F 883	Continued From page 16	F 883		

date.

A review of Resident #2's EHR revealed that the facility staff had documented consent refused for pneumovax dose 1 (no date) under the immunization tab in the EHR. For 10/03/2016, the facility had documented "Historical." During the record review, the surveyor was unable to locate any further information regarding historical.

On 01/18/2021, the facility administrator and interim DON (director of nursing) were notified that the portion of the consent form that would have been required for the consent to be accepted or declined for the pneumonia vaccine had not been marked.

The facility policy regarding the pneumococcal vaccinations with an effective date of 02/2017 read in part, "All residents admitted to the facility will be given the opportunity to receive the pneumococcal vaccine per physician's order...The admitting nurse will research the medical record and resident history to determine if pneumococcal has ever been given..."

On 01/18/2021, the facility administrator indicated to the surveyor that the interim DON was reviewing Resident #2's clinical record in regards to the pneumonia vaccine.

No further information regarding this issue was provided to the surveyor prior to the exit conference on 01/19/2021.