STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125029	A. BUILDING _____ B. WING _____	12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 KAWAIHAU ROAD KAPAA, HI 96746

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 11/28/23-12/01/23. The facility was not in compliance with 42 CFR 483 Subpart B. Facility Reported Incident (ACTS 10660) was also investigated. Non-compliance was found in ACTS 10660. Survey Census: 49 Sample Size: 17	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		1/5/24

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

Electronically Signed | 01/05/2024

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F 578	Continued From page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to assure one of two residents (R)17 sampled exercised their right to formulate an advanced health care directive (AHCD). This deficient practice has the potential to cause harm to residents when they are provided medical care that is not in accordance with their wishes. Findings include: On 11/29/23 at 10:12 AM record review found R17's AHCD did not include two witness signatures or an official notary seal indicating the signed document was acknowledged before a notary public in the state. The AHCD signed by R17 on 06/01/05 documented "(14) WITNESS: This power of attorney will not be valid for making health-care decisions unless it is either (a) signed by two qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or	F 578	1. Upon notification of this deficient practice, the Social Worker contacted the family of R17 to make arrangements to obtain a new Advance Health Care Directive (AHCD) the meets the requirements. The Power of Attorney (POA) is currently out of the country, but will come in upon her return to Hawaii to complete a new AHCD. 2. All residents do have the potential to be affected by this deficient practice. 3a. Nursing staff reviewed the AHCDs for all current residents in the facility to validate that requirements were met. 3b. Upon admission of new and returning residents, the Social worker or designee will verify that all AHCDs meet the requirements to be considered valid. As per policy, residents will be informed of	

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F 578	Continued From page 2 (b) acknowledged before a notary public in the state." The document included a statement "WITNESS my hand and official seal" for the Notary Public, a signature and date under "My commission expires," but no official seal. On 11/29/23 at 02:12 PM, Social Worker (SW) confirmed the notarized seal was missing from the form and will inquire with family for a better copy that may include the seal. On 11/30/23 at 02:47 PM, SW stated she was not able to get a copy with the notarized seal from family and was pending their return to the State.	F 578	their rights to accept or refuse medical or surgical treatment on admission and provided information on Advance Health Care Directives. 3c. Findings from the review of current residents and for each new resident admission going forward will be logged on the LTC AHCD/POLST Tracking log. An AHCD that meets state and facility requirements will be requested when the provided AHCD is found to be deficient. 3d. LTC DON or designee will monitor the log monthly to validate that all new admissions have been entered and will visually verify that their AHCD is in their hard copy chart on the unit. 4. LTC DON or designee will report findings from monthly monitoring to HPIC for the next three consecutive bi-monthly meetings. Bi-annual reporting to HPIC will continue thereafter.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.	F 584		12/29/23

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F 584	Continued From page 3 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain a safe environment as evidenced by having four cracked, broken electrical outlet covers in the resident's room. Findings include: Observations on 11/28/23 at 01:00 PM in Room 16 revealed four different electrical outlet covers	F 584	1. All broken outlet covers were immediately replaced in Room 16 by maintenance staff. 2. All residents have the potential to be affected by this deficient practice. 3a. All outlets in the LTC Facility were visually inspected to ensure the safety of	

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F 584	Continued From page 4 were cracked and broken off. The broken sections were around two centimeters wide and created a risk for accident hazards. During staff interview on 11/29/23 at 02:00 PM, Maintenance Supervisor (Maint) acknowledged the cracked, broken electrical outlet covers. Maint further stated that they would have the covers replaced immediately.	F 584	the residents. 3b. Stainless Steel outlet covers were ordered to replace the plastic ones in all of the LTC patient rooms to prevent this situation from reoccurring. Upon arrival, they will be installed. 3c. LTC and EVS staff education will be provided by LTC designee and EVS Manager addressing the procedure to report observed safety issues in the LTC facility. 3d. Maintenance will add an ongoing monthly Resident Room Rounding Schedule to their Preventive Maintenance Annual Calendars. 3e. Facility safety concerns identified on rounding will be either immediately repaired by Maintenance staff or reported to Maintenance Supervisor and LTC DON for follow-up when repairs cannot be immediately done. 3e. Maintenance Supervisor or designee will review findings from Resident Room Rounding done by maintenance each month. 4. Maintenance Supervisor or designee will report findings from rounding with actions taken to HPIC for the next three consecutive bimonthly meetings.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		12/29/23

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F 609	Continued From page 5 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of the facility's policy and procedures and staff interview, the facility failed to immediately report allegation of abuse to the adult protective services (APS) in accordance with State Law for a facility reported incident related to allegations of abuse. Findings include:	F 609	1. The Regional Risk Manager contacted Adult Protective Services (APS) on 12/1/23 to report this unsubstantiated allegation and review the investigation. APS worker informed Regional Risk Manager that we should only report to them if there is a suspicion of abuse. 2. All residents do have the potential to	

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F 609	Continued From page 6 The facility submitted an Event Report to the State Agency regarding an allegation of staff to resident abuse for an incident on 10/29/23. On 11/24/23, Resident (R) 48 reported Certified Nurse Aide (CNA) 12 was water boarding him, CNA12 put soap on her gloves, rubbed it on his face then stood at the end of the shower gurney and sprayed him. The facility completed an investigation and was unable to substantiate the allegation. On 11/30/23 at 01:24 PM interview with R48 was done. R48 confirmed he reported the incident to the Director of Nursing (DON) and continued to report to the State Agency (SA) that he felt like he was drowning when CNA12 sprayed the water on his face. A review of the facility's "Incident Report" submitted on 11/24/23 and "Event Report" submitted on 11/29/23 by the facility found this allegation was not reported to APS. A review of the facility's policy and procedure for abuse and neglect entitled "Freedom From Abuse and Neglect" with an effective date of 07/10/23 refers to an attached "Outside Agency Reporting Information" sheet to determine if report to APS is necessary. Review of the "Outside Agency Reporting Information" sheet attached documented "Verbal report due within 24 hours of the event; to be followed by fax of written report" to APS. Criteria for reporting to APS include "Accusation or report of abuse by resident or family member of vulnerable adult..." On 11/30/23 at 02:16 PM interviewed the DON was done. DON confirmed R48 reported the incident to her and the Social Worker (SW). DON	F 609	be affected by this deficient practice. 3a. LTC DON or designee will report all allegations of resident abuse to APS within the required time frame going forward to allow them to make the determination if they should open an alleged abuse investigation outside of the facility□s internal investigation. 3b. Reporting requirements to the Hawaii Office of Health Care Assurance (OCHA) remains unchanged. 3c. Policy 100-102-6, Freedom from Abuse and Neglect, was updated to delineate reporting requirements and staff education was provided. 3d. A LTC Reporting Log was created to document and track all OCHA and APS reporting. 3e. LTC DON or designee will monitor all abuse allegations to ensure reporting was timely and that documentation was complete. Staff re-education will be done annually and when indicated. 4. LTC DON or designee will report findings from the monitoring to HPIC for the next three consecutive bi-monthly meetings and/or until 100% compliance is achieved.	

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F 609	Continued From page 7 further confirmed a report was not made to APS regarding the allegation. On 11/30/23 at 02:28 PM interview with Social Worker (SW) was done. SW confirmed R48 also reported the incident to her, and she did not report the allegation to APS. SW reported the facility usually does the event reporting and internal investigation prior to reporting to APS. On 12/01/23, the Regional Chief Quality Officer (RCQO) provided an internal email documenting APS not wanting to process reports that are already deemed unsubstantiated from the facility. The email did not include an official memo, official letter, or official exemption, that documents health care facilities are exempt from mandate reporting allegations of abuse according to state law. RCQO reported the facility does not report all allegations of abuse to APS unless the facility substantiates the abuse. This practice did not allow APS to make the determination to open an alleged abuse investigation outside of the facility's internal investigation.	F 609		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		1/5/24

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F 812	Continued From page 8 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview with staff member, the facility failed to ensure food products were stored under sanitary condition and discarded before the expiration or used by date. This failed practice could place all facility residents at risk for food-borne illness. Findings Include: On 11/28/23 at 09:25 AM, concurrent observation and interview was done during the initial kitchen tour with Kitchen Manager (KM). 1) Observed in the "kitchen helper three-door fridge," a clear squeeze bottle labeled "LV" with the date of "11/04." Inquired with KM what was in the clear squeeze bottle, and she stated "Lemon vinegar juice. KM further stated the date "11/04" indicated when the lemon vinegar juice was made and should have been discarded a week from when it was made. KM confirmed the lemon vinegar juice was made longer than one week ago. 2) In the walk-in produce refrigerator, observed a large metal bowl of cooked macaroni, uncovered. KM confirmed the macaroni should be covered and will be used for tomorrow's lunch. Further observation of one container of cottage cheese	F 812	1. Kitchen Manager immediately discarded the questionable items into the garbage. The cooked macaroni in the refrigerator was covered and labeled immediately. 2. All residents, staff and visitors that eat facility prepared meals have the potential for being impacted by this deficient practice. 3a. Kitchen Manager met with staff to discuss survey findings. Re-education on proper food storage and labeling guidelines per Food Service Safety Professional Standards was provided to all foodservice staff. 3b. The Kitchen Manager of the day or designee will monitor for compliance with the guidelines on food storage and labeling throughout the department. 3c. Any food found to be stored or labeled incorrectly will be discarded and dietary staff will be re-educated on the proper storage and labeling procedures. Progressive disciplinary actions will be imposed on staff found to have repetitive	

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F 812	Continued From page 9 with the use by date of 11/16/23 and two low-fat cultured buttermilk with the use by date of 11/26/23. KM confirmed the items were past the use by date and should have been discarded. 3) In the "two-door freezer," observed a bag of opened, exposed, French fries not sealed and not dated. KM confirmed the bag of fries should have been sealed and a date indicating when it was opened. 4) In the "reach-in fridge," observed chopped spam, chopped green onion, and chopped fish cake with the date "11/19". KM stated the refrigerator is used to keep prepped dinner and the spam, green onion, and fish cake should have been thrown out a week from being made. The food items were made on "11/19". 5) In the dry goods pantry, observed 11 bottles of nutritional shakes with a use by date of 09/2023 and two large containers of cranberry sauce dated 11/18/21. KM confirmed the nutritional shakes and cranberry sauce should have been discarded. Review of the facility's policy and procedure "Food Preparation and Storage" effective 05/18/21 documented "All items prepared and stored will be portioned out in individual containers and covered ...items will be labeled with the date ...all chilled food items not in original container will be disposed within 72 hours of labeled date ...Leftovers will be placed in the main walk-in refrigerator and available for use within 72 hours of labeled date. All unused portions will be disposed."	F 812	non-compliance. 3d. Findings from monitoring will be documented on the Food Storage Log. The Food Storage Log will be analyzed for trends on an ongoing basis and tabulated for bi-monthly reporting. 4. Regional Food Service Manager or designee will report findings from log monitoring to HPIC for 3 consecutive bi-monthly meetings and/or until 100% compliance met.	
F 842 SS=D	Resident Records - Identifiable Information	F 842		12/29/23

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F 842	Continued From page 10 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; (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	F 842		

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F 842	Continued From page 11 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: Based on record review and interviews, the facility failed to accurately document the code status of one of the residents sampled (Resident (R) 5). This deficient practice has the potential to adversely affect the level of care for all residents in the facility. Findings Include: A review of R5's Electronic Health Record (EHR)	F 842	1. LTC Medical Director and Social Worker met with resident R5 and her POA to validate her wishes. R5□s POLST was updated to match the AHCD and her medical record was updated. 2. All residents do have the potential to be affected by this deficient practice. 3a. Each resident□s POLST and AHCD	

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SAMUEL MAHELONA MEMORIAL HOSPITAL	4800 KAWAIHAU ROAD KAPAA, HI 96746

(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 842	Continued From page 12 was conducted on 11/29/23. R5's EHR contained a completed document titled, "Provider Orders for Life-Sustaining Treatment (POLST)," dated 03/14/17. The POLST document on section "A" titled, "Cardiopulmonary Resuscitation (CPR), indicated that R5 had chosen, "Do not attempt resuscitation/DNAR (Allow natural death). Further review of R5's EHR contained a completed document titled, "Hawaii Advance Heath Care Directive," dated 09/21/21. R5's completed advanced health care document indicated under, "End of Life Decisions," section that R5 had chosen, "I want medical treatment that would prolong my life as long as possible within the limits generally accepted health care standards." A review of R5's EHR indicated that her code status was currently Do Not Resuscitate (DNR). Concurrent record review and interview was conducted on 11/29/23 at 02:27 PM with facility Social Worker (SW). SW was presented with a copy of R5's POLST and Advanced Health Care Directive (AHCD) documents. SW conducted a review of R5's records in the hard chart at the nurse's station. R5's hard chart indicated that R5's code status was currently DNR. SW stated that it should have been updated and she would discuss it with the medical doctor. Concurrent record review and interview was conducted on 11/29/23 at 02:33 PM with the Director of Nursing (DON) at the nurse's station. DON was provided with a copy of R5's POLST and AHCD documents to review. After reviewing R5's documents, DON stated that R5 no longer want DNR status, and the facility should have	F 842	will be reviewed upon admission and annually thereafter to ensure that the resident/POA□s wishes continue to be reflected on the documents and in the medical record. 3b. Upon admission, the Social worker or designee will verify that the POLST and AHCD reflect the resident/POA□s wishes and enter the findings on the LTC AHCD/POLST Tracking log. 3c. The LTC DON/designee will work with physician annually to validate that the resident/POA□s wishes are reflected in their current POLST and AHCD. Validation/changes will be documented on the LTC AHCD/POLST Tracking log. 3d. Both the Social Worker and the LTC DON will monitor the LTC AHCD/POLST Tracking log. Identified issues will be addressed at the weekly Interdisciplinary Group meeting. 4. LTC DON or designee will report findings from the monitoring to HPIC for the next three consecutive bi-monthly meetings and/or until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 13 updated R5's records.	F 842		
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 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	F 883		1/5/24

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F 883	Continued From page 14 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 interviews and record review, the facility failed to ensure that all residents who were eligible for the Pneumococcal vaccine received it and/or their medical record indicated that the resident or resident's representative were provided education regarding the benefits and potential side effects of the Pneumococcal vaccine. This deficient practice places one of five residents (Resident (R) 11) sampled at risk for developing pneumonia related complications. This deficient practice has the potential to affect all the residents in the facility. Findings Include: Record review of R11's Electronic Health Record (EHR) was conducted on 11/30/23. R11's EHR indicated that her Pneumococcal vaccination status was "unknown."	F 883	1. R11□s POA was immediately contacted to obtain permission to administer Pneumococcal vaccine. Approval was obtained and R11 was given the Pneumococcal vaccine. Documentation was place in R11□s Electronic Medical Record (EMR). 2. All residents do have the potential to be affected by this deficient practice. 3a. The LTC DON or designee will monitor each resident□s immunization history quarterly to verify residents are provided information on the vaccines they are eligible to receive and documentation exists to support they have been offered & received/declined the vaccine. Findings from monitoring will be documented on	

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F 883	Continued From page 15 Interview was conducted with the facility's Infection Preventionist (IP) on 11/30/23 at 02:29 PM in the conference room. IP indicated that she could not find any documentation in R11's EHR for offering or declining the Pneumococcal vaccine. Record review and Interview were conducted with the Regional Chief Quality Officer (RCQO) on 11/29/23 at 02:33 PM in the conference room. RCQO went through R11's EHR and could not find any documentation that the Pneumococcal vaccine was administered prior to R11's admission into the facility. RCQO also was not able to find documentation on the facility administering, offering, or providing education to R11 or R11's representative regarding Pneumococcal vaccination.	F 883	the LTC Vaccination Tracking Log. 3b. New policy #550-125-4, Resident Vaccinations, was created to outline the process for immunizing residents. New form Resident Vaccination Education Acknowledgement, Consent/Declination Form was created to document immunization education, offering and consent/declination. 3c. LTC staff will be educated on new policy and form. 4. LTC DON will report findings from the monitoring to HPIC for the next three consecutive bi-monthly meetings and/or until 100% compliance is achieved.	