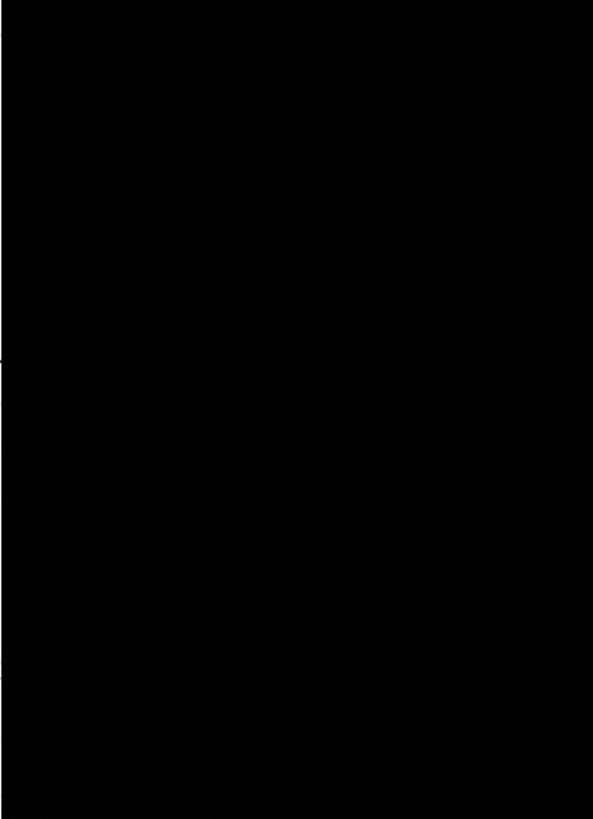


Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION RECOMMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

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

4 123	Continued From page 1 	4 123	Continued from page 1 and choice (respect for privacy) and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	
-------	---	-------	---	--

4 136	11-94.1-30 Resident care The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to: (1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown;	4 136	4 136-11-94.1-30 Resident care 1.  the care plan was reviewed (2/13/15) and did include the following interventions: 	02/13/15
-------	--	-------	--	----------

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

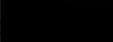
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	<p>Continued From page 2</p> <p>(4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.</p> <p>This Statute is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to maintain [REDACTED] for 1 Resident, [REDACTED] of the 28 residents reviewed.</p> <p>Findings include: [REDACTED]</p>	4 136	<p>Continued from page 2.</p> <p>[REDACTED]</p> <p>Care plan was updated on 10/1/14.</p> <p>All the above were care planned and documented.</p> <p>[REDACTED] the resident's care plan was reviewed and revised by the DON and ADON based on the resident's abilities and choice on 02/05/15.</p> <p>[REDACTED]</p> <p>Staff is to check/document the proper functioning of the alert alarm at the beginning of each shift; and to ensure that it is turned on and functioning when the resident changes location. Staff was counseled to follow care plans, which is to stand outside the bathroom door while</p>	

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	---	--

NAME OF PROVIDER OR SUPPLIER
PALOLO CHINESE HOME

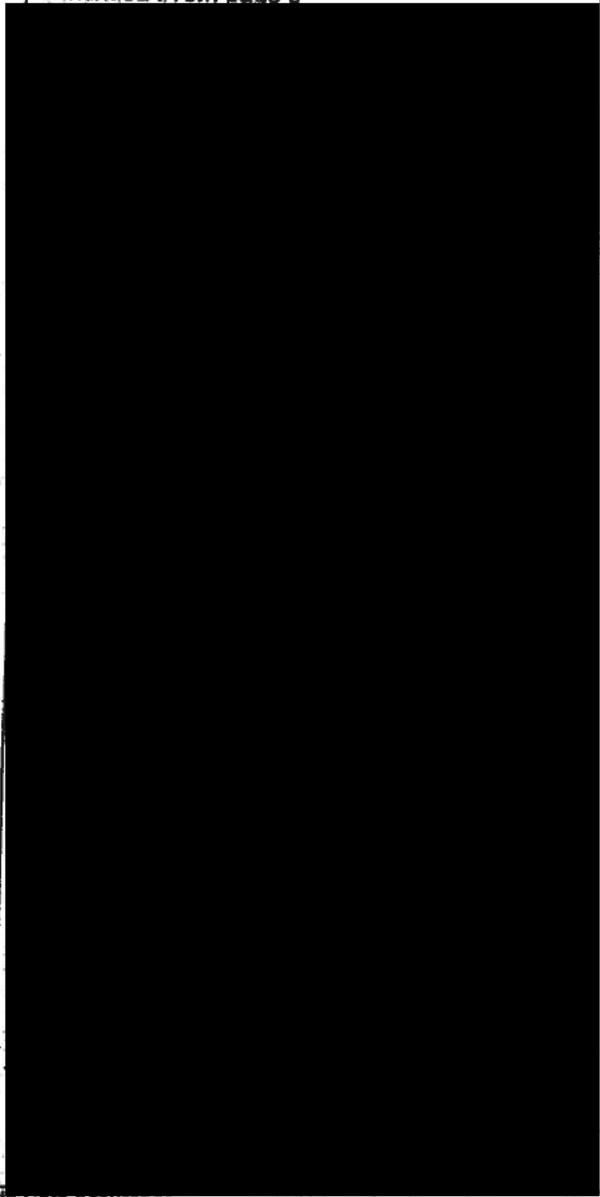
STREET ADDRESS, CITY, STATE, ZIP CODE
**2459 10TH AVENUE
HONOLULU, HI 96816**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 4 	4 136	Continued from page 4. beginning of the shift. Staff must follow care plans and not leave residents unattended while using the toilet on 02/02/15 – 02/13/15. All other staff (Dietitian, Food Service Manager) was in-serviced on 02/10/15. 4. The DON/designee will audit each month that the resident care plans are based on the resident's comprehensive assessment to ensure that a resident receives necessary treatment and services to prevent  unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having  receives necessary treatment and services to promote healing, prevent infection and prevent  from developing; alert alarms are being checked that it is on and functioning at the beginning of each shift and that staff are not leaving residents unattended  and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	02/16/15

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	--	--

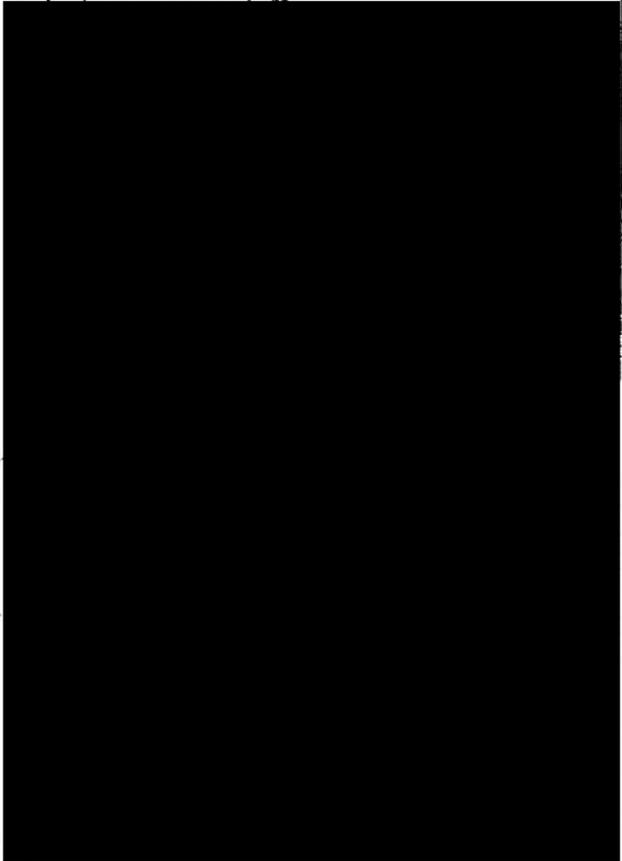
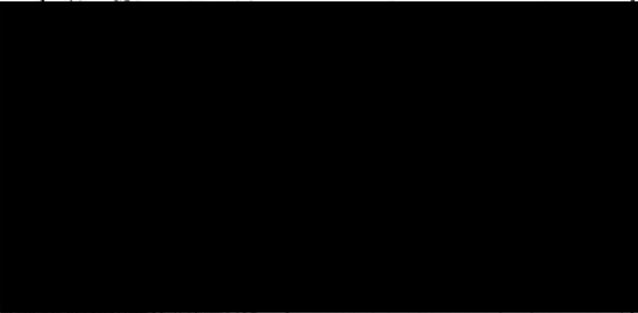
NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2458 10TH AVENUE HONOLULU, HI 96816
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 5 	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 6  	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	---	--

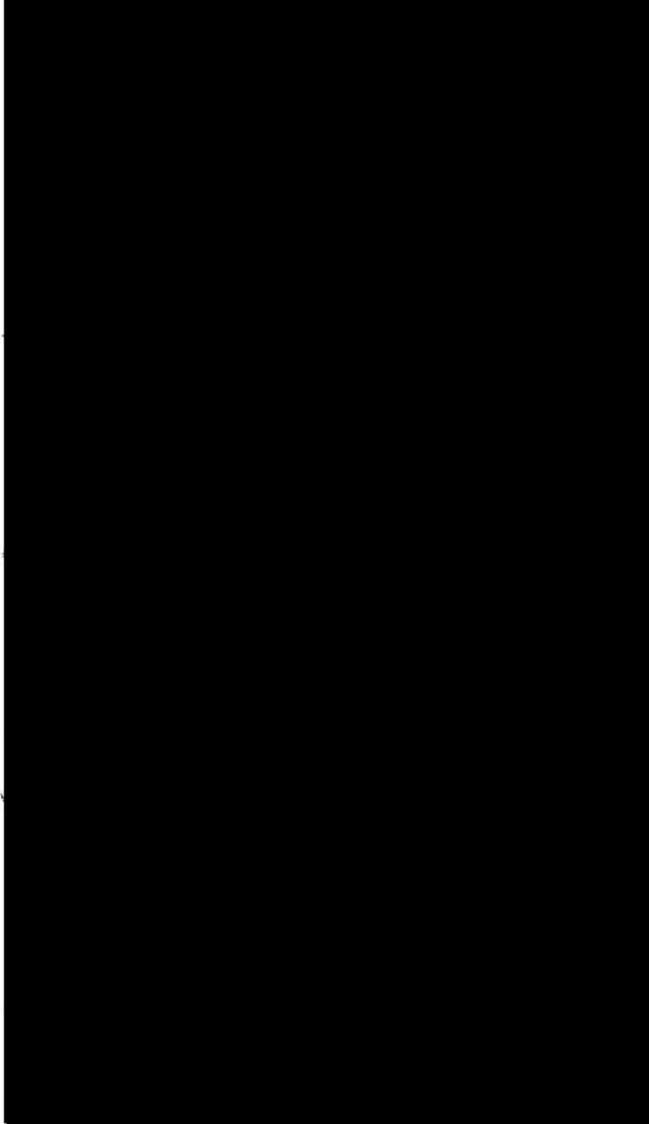
NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 7 	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 8 	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	---	--

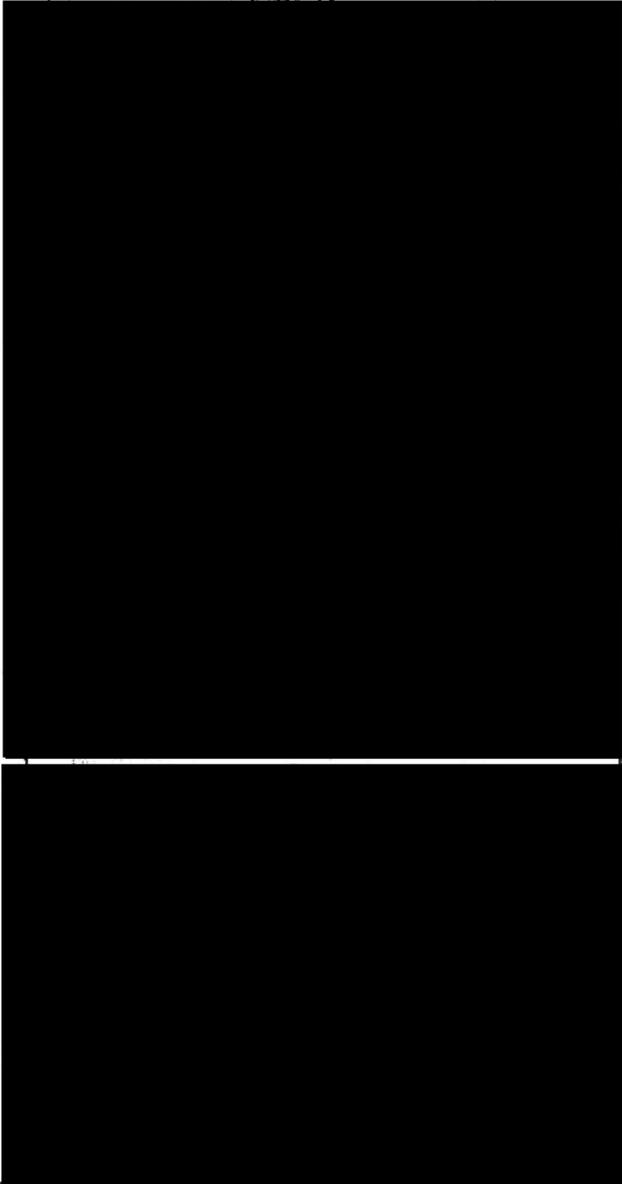
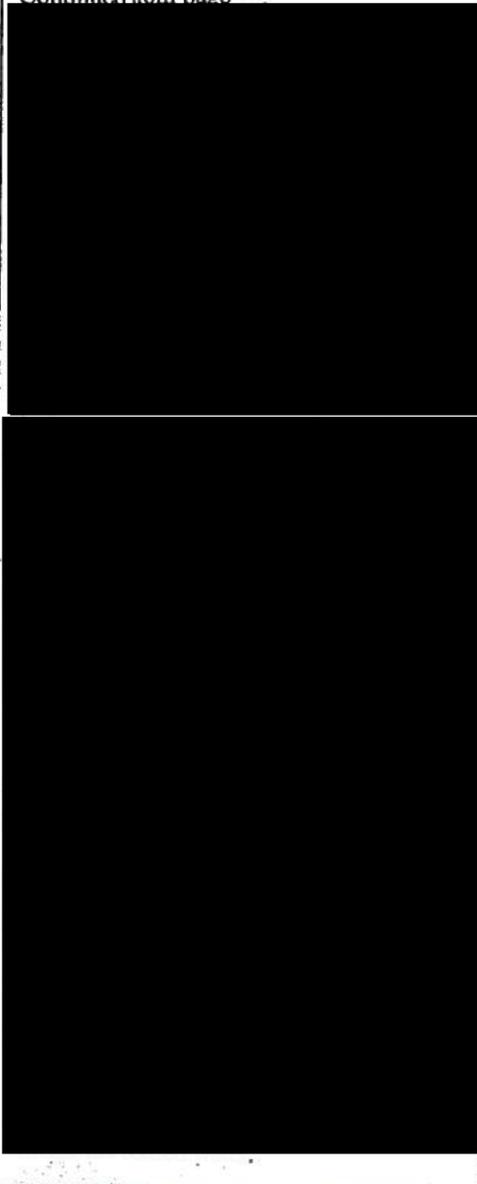
NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10 H AVENUE HONOLULU, HI 96816
---	---

(X4) ID-PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 174	Continued From page 9	4 174		
4 174	<p>11-94.1-43(b) Interdisciplinary care process</p> <p>(b). An individualized, interdisciplinary overall plan of care shall be developed to address prioritized resident needs including nursing care, social work services, medical services, rehabilitative services, restorative care, preventative care, dietary or nutritional requirements, and resident/family education.</p> <p>This Statute is not met as evidenced by: Based on record review and interview with staff members, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical needs that are identified in the comprehensive assessment for 3 of 14 sampled residents [REDACTED] of the 26 residents reviewed.</p> <p>Findings include: [REDACTED]</p>	4 174	<p>4 174-11-94.1-43(b) Interdisciplinary care process</p> <p>1. By 2/12/15, for [REDACTED] the care plan was reviewed and revised by the SW, Dietitian and Nurses to include the following interventions: Non-pharmacological interventions for [REDACTED]. Ensure [REDACTED] resident's safety and come back in 5 minutes. [REDACTED]</p> <p>For [REDACTED] the care plan was reviewed (2/13/15) and did include the following interventions: [REDACTED]</p>	2/16/15

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 174	Continued From page 10 	4 174	Continued from page 	

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

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

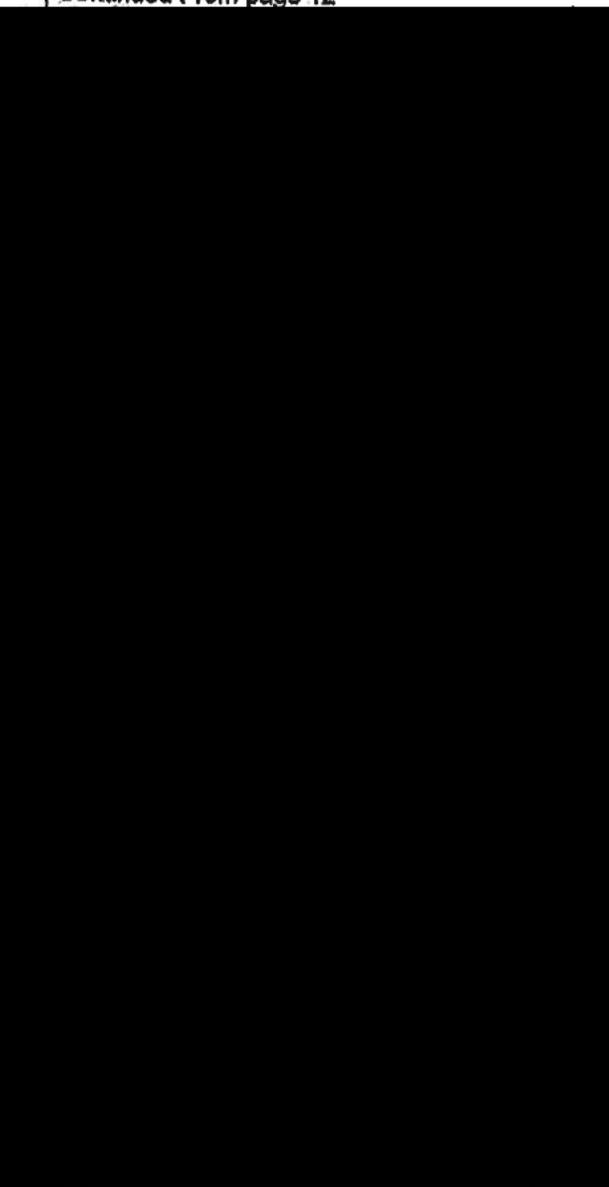
4 174	Continued From page 11	4 174	Continued from page 11.	
			2. On 2/5/15-2/13/15 all resident care plans were audited, reviewed and revised by the SW, Dietitian, and Nurses to ensure that the following is care planned: includes non-pharmacological interventions for residents on [REDACTED] medications; side effects interventions/monitoring related to medications use; interventions related to refusal of care; interventions to prevent [REDACTED] and fluid preferences.	02/13/15
			3. On 02/02/15 – 02/13/15 all Licensed Nurses, SW, Dietitian and CNAs (current, new and annually) were in-serviced on the requirements that care plans must be comprehensive and include non-pharmacological interventions for residents on [REDACTED] medications; side effects interventions/monitoring related to medications use; interventions related to refusal of care; interventions to prevent [REDACTED] and fluid preferences.	02/13/15

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER
PALOLO CHINESE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**2459 10TH AVENUE
HONOLULU, HI 96816**

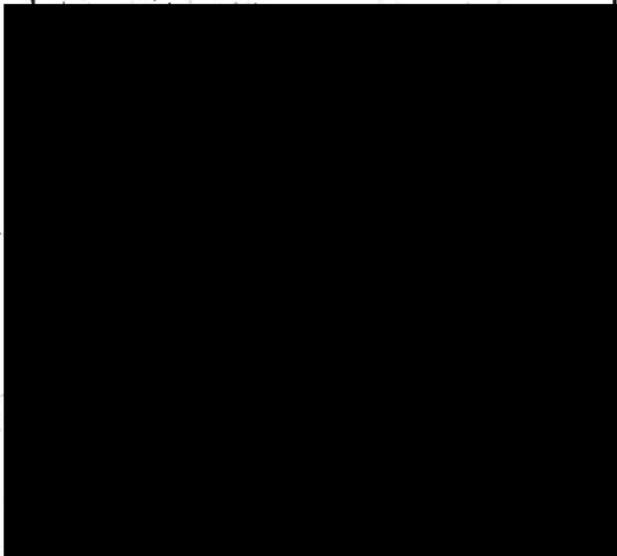
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 174	Continued From page 12 	4 174	Continued from page 12. All other staff (Dietitian, Food Service Manager) was in-serviced on 02/10/15. 4. The DON/designee will audit each month the care plans to ensure that it is comprehensive and includes interventions for non-pharmacological interventions for residents on [redacted] medications; side effects interventions/monitoring related to medications use; interventions related to refusal of care; interventions to prevent [redacted] and fluid preferences and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	02/16/15

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

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

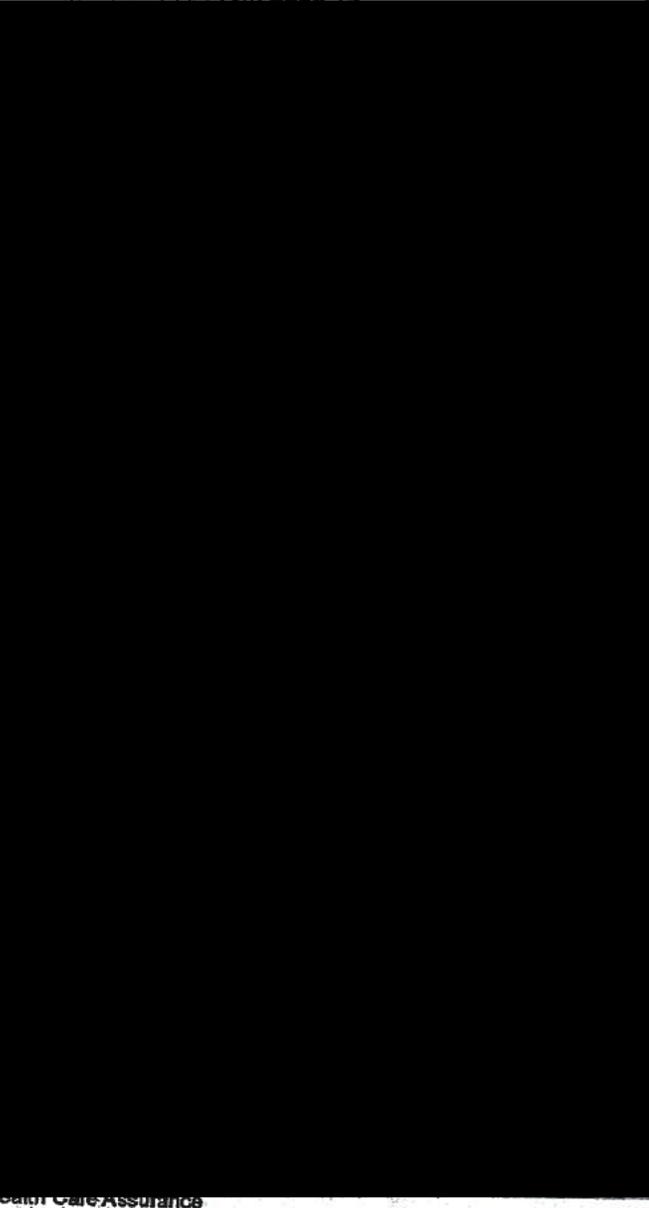
4 174	Continued From page 13 	4 174		
-------	--	-------	--	--

4 194	<p>11-94.1-46(k) Pharmaceutical services</p> <p>(k) Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview, and review of medication administration guidelines, the facility failed to ensure that medications were stored and labeled with the resident's name and kept medications locked/observed at all times.</p> <p>Findings include: </p>	4 194	<p>4 194-11-94.1-46(k) Pharmaceutical services</p> <p>1. On 02/03/15  was counseled/observed by the DON/ADON to not leave medications on top of the medication cart unlabeled and unattended by the DON/ADON.</p> <p>2. All Lic. Nurses were in-serviced/observed by the DON/ADON on the policy that no medications are to be left unattended and unlabeled, such as on the medication cart completed by 02/13/15.</p> <p>3. All new Lic. Nurses and annually will be in-serviced on the policy that no medications are to be left unattended and unlabeled, such as on the medication cart on 02/02/15 - 02/13/15.</p> <p>4. The DON/designee will audit each month</p>	<p>02/03/15</p> <p>02/13/15</p> <p>02/13/15</p> <p>02/16/15</p>
-------	---	-------	---	---

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

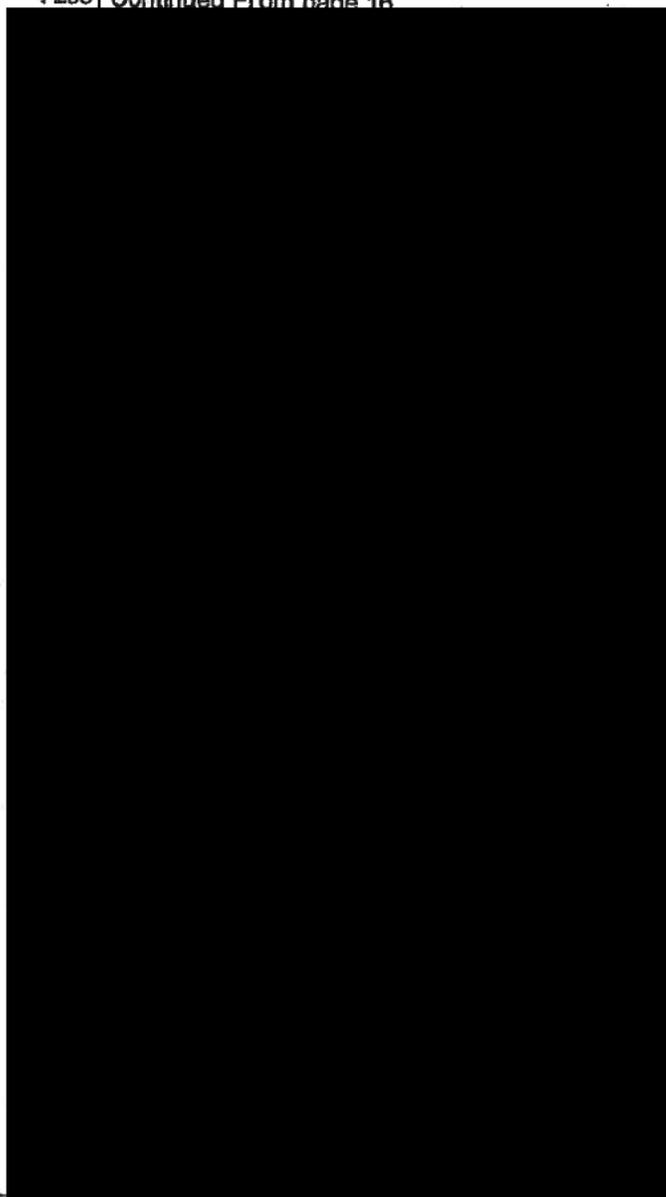
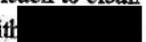
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 194	Continued From page 14 	4 194	Continued from page 14. that Lic. Nurses are not leaving medications unattended and unlabeled, such as on the medication cart and the results will be reported to the QA Committee each quarter. Completion date 02/16/15.	

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
---	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

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

4 203	Continued From page 16 	4 203	Continued from page 16. hands and proceed to brush a resident's hair. Use of "orange tops" with bleach to clean equipment with residents with  on 02/02/15 - 02/13/15. All Lic. Nurses were educated/observed on the requirement to wash hands before and after each treatment and to wash/sanitize hands before administering medications on 02/02/15 - 02/13/15. All housekeepers were trained on cleaning the shower chair daily with disinfectant, including the underneath. There will be a sign at the entrance of the door with a "C" to indicate that they need to use a bleach solution on 2/13/15. All shower chairs will be power washed every other month. 3. All new Lic. Nurses and CNAs and annually will be in-serviced/observed on cleaning equipment before and after each use, not to clean from dirty to clean such as cleaning the floor then the shower chair with same towel and placing slippers on the resident's feet without washing or sanitizing hands and proceed to brush a resident's hair. Use of "orange tops" with bleach to clean equipment with residents with  on 02/13/15. Lic. Nurses are washing/sanitizing their hands after/before each treatment and before administering medications on 02/13/15. All new housekeepers and annually will be ins-serviced on the daily cleaning of the shower chair, including the underneath. Use of bleach solution for	02/13/15
-------	---	-------	---	----------

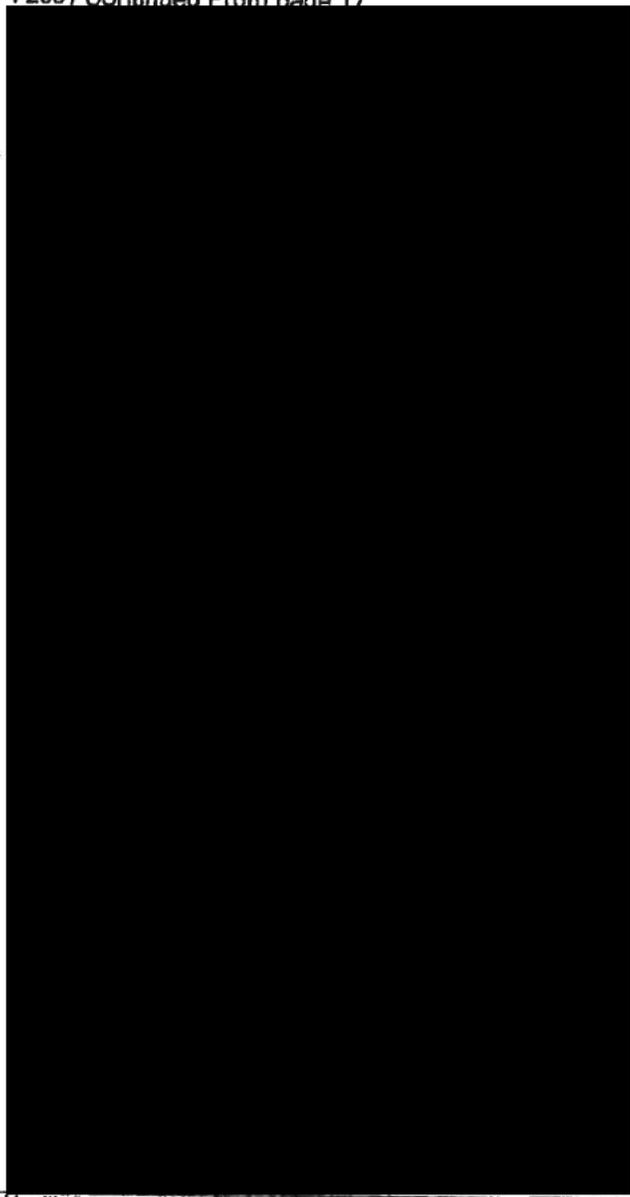
Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
--	---

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

4 203 Continued From page 17

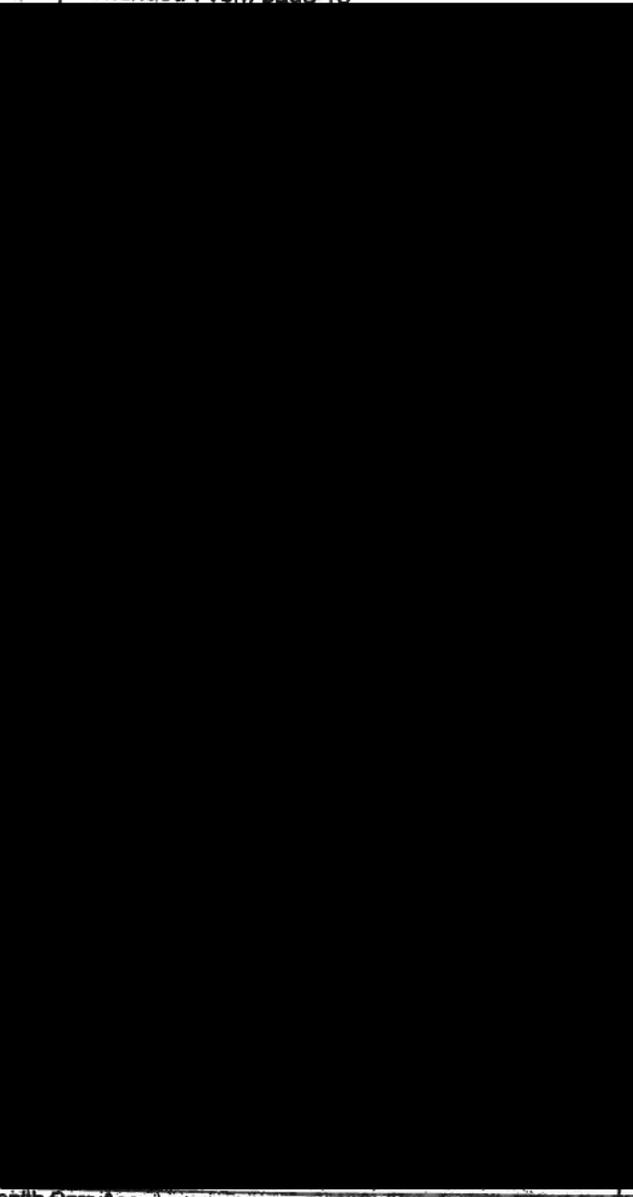


4 203	<p>Continued from page 17. with [REDACTED] on 2/13/15.</p> <p>4. The DON/designee will audit/observe each month that Lic. Nurses/CNAs are cleaning equipment before and after each use, not to clean from dirty to clean such as cleaning the floor then the shower chair with same towel and placing slippers on the resident's feet without washing or sanitizing hands and proceed to brush a resident's hair. The DON/designee will audit/ observe each month that the staff use of "orange tops" with bleach to clean equipment with residents with [REDACTED] and Lic. Nurses are washing/ sanitize their hands after/before each treatment and before administering medications. The results will be reported to the QA Committee each quarter. Completion date 02/16/15.</p>	02/16/15
-------	--	----------

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION : A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	Continued From page 18 	4 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AMENDED POC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/29/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PALOLO CHINESE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2459 10TH AVENUE HONOLULU, HI 96816
---	---

(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)	(X6) COMPLETE DATE
4 203	Continued From page 19 	4 203		