STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA). The facility was not in compliance with 42 CFR 483 Subpart B. Survey Dates: 03/29/22 to 04/01/22 Survey Census: 96 Sample Size: 34	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		5/2/22

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

Electronically Signed | 04/22/2022

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F 655	Continued From page 1 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the baseline care plan developed for one resident (Resident (R)179) sampled was person-centered. R179 was admitted with a fractured right humerus (the long bone in the arm that runs from the shoulder to the elbow) and was receiving regularly scheduled pain medication that meet professional standards of quality care. R179's baseline care plan did not include a focus, goals, or interventions for pain management. As a result of this deficiency, the resident is at risk of unrelieved pain and the potential for harm. Findings include: R179 was admitted to the facility on 03/11/22 after falling at home and sustaining a fracture of the right humerus (the long bone in the arm that runs from the shoulder to the elbow). R179's admission Minimum Data Set (MDS) with an	F 655	R179□s baseline care plan has been updated to include a focus, goals/interventions for pain management. DON/designee completed audit of current residents to verify baseline care plans are in place and appropriate. Identified inconsistencies addressed. DON/ designee initiated further education to licensed nurses, MDS nurses and nurse managers on 4/22/22 regarding required elements of baseline care plans DON/designee will complete 5 audits weekly X4 weeks then 5 audits monthly X2 months to validate that personalized baseline care plan(s) are completed. Administrator/designee will present findings at the facility□s Quality Assurance and Performance	

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F 655	Continued From page 2 Assessment Reference Date (ARD) of 03/17/22 documented in Section C, Cognitive Patterns, a Brief Interview of Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact (a reliable source of information. Section J, Health Conditions J0100. Pain Management documented at any time in the last 5 days that R179 has (A) received a scheduled pain medication, (B) received PRN (pro re NATO, as needed) pain medication or was offered and declined, and (C) did not receive non-medication intervention for pain. On 03/31/22 at 08:35 AM, while observing Registered Nurse (RN)22 administer medications to R179. During the medication administration, R179 reported having unrelieved pain during the night shift to RN22. R179 stated he/she requested pain medication but was informed that he/she did not have PRN medication for pain relief, only scheduled medication. R179 informed RN22 that he/she wants to skip the lunch pain medication and save it for the night shift. On 03/31/22 at 09:00 AM, conducted a review of R179's Electronic Medical Records (EMR). Review of the Physician Orders documented an order for Tylenol (Acetaminophen) Tablet 325 milligrams (mg) 2 tablets (total dose 650 mg) by mouth three times (08:00 AM, 12:00 PM, and 4:00 PM) a day for pain management was started on 03/12/22. There were no physician orders to manage R179's reported pain after the scheduled Tylenol 650 mg after 4:00 PM. Review of R179's person-center baseline and comprehensive care plan did not include a focus, goals, or interventions for pain management to meet the professional standards of quality care. On the first page of the care plan there were special	F 655	Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 655	Continued From page 3 instructions that documented the reason R179 was receiving skilled PT/OT/Nursing Services are related to weakness s/p fall sustained Right humerus fracture,-humeral shaft displaced anteriorly, Diabetes Mellitus, HLD (hyperlipidemia), HTN (hypertension; high blood pressure), back pain, renal insufficiency syndrome, thrombocytopenia, and pain management. A nursing progress note by RN88 (night shift,11:00 PM-7:00 AM) documented R179 complained of mild pain to the arm/hand during shift and asked for Tylenol. No PRN orders for Tylenol or pain medication available. RN88 informed R179 the physician (P)9 would be contacted for PRN medication or scheduled Tylenol instead. On 04/01/22 at approximately 11:08 AM, conducted a concurrent record review and interview with the Regional Nurse Consultant (RNC), Director of Nursing (DON), and Infection Prevention (IP). The RNC and DON confirmed that although the pain evaluation completed on 03/11/22 prompted a care plan for pain management, R179's baseline and comprehensive care plan did not include pain management and it should have been addressed.	F 655		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure two residents	F 677	R61 no longer resides at the facility. R39 is receiving assistance with meals, as	5/2/22

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F 677	Continued From page 4	F 677		

(Resident (R)39 and R61) who are unable to carry out activities of daily living received the necessary services to maintain good nutrition in a timely manner. R39 waited 40 minutes for staff to assist with set-up up for lunch while other resident's in the room ate.

Findings include:

1) R39 was admitted to the facility on 10/26/21 with diagnoses that include heart failure and Dementia. R39's quarterly Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 02/22/22, Section G., Functional Status G0110, Activities of Daily Living (ADL) Assistance H. Eating addresses how a resident eats and drinks (orally), regardless of skill documented the resident requires limited assistance (resident is highly involved in activity; staff provides guided maneuvering of limbs or other non-weight-bearing assistance and requires the physical assistance of one person. Section K-Swallowing/Nutritional Status, K0300. Weight Loss documented R39 has had a loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regime.

On 03/29/22 at 12:15 PM, entered Room 111 and observed three of four residents residing in the room were eating lunch. Approached R39, observed the resident lying in bed (the head of bed elevated approximately 35 degrees), with his/her lunch tray, covered, on the bedside table. The bedside table was positioned out of R39's reach in height and distance and the resident was unable to set-up her lunch tray independently. Inquired with R39 if he/she had already eaten or is waiting for staff assistance. R39's roommate responded, "She needs help setting up". R39 needed.

DON/Designee completed a baseline audit on 4/19/22 to verify residents are provided with needed meal assistance. Identified inconsistencies addressed.

DON/ designee initiated further education to nurses and CNAs on 4/22/22 regarding ADL care and providing assistance with meals

DON/designee will complete random observations of residents requiring assistance with meals to verify the needed assistance is being provided in a timely manner, 5 observations weekly X4 weeks then 5 observations monthly X2 months. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.

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F 677	Continued From page 5	F 677		

reached for the bedside table and stated she was hungry but could not move the bedside table so she could eat. R39 waited until 12:55 PM (40 minutes later) when staff entered the room and set-up the resident for lunch at 12:55 PM. Observed R39 eating independently once the bedside table and food were within reach.

On 04/01/22 at approximately 11:15 AM, conducted a concurrent record review and interview with the Regional Nurse Consultant, Director of Nursing (DON), and Infection Prevention Registered Nurse (IP) for R39. Shared my observation of R39 waiting 40 minutes for staff to set up her lunch tray so she could eat. The ED and DON confirmed that staff should have set the resident up with lunch prior to leaving the room and the resident should not have to wait 40 minutes for assistance.

2) R61 was admitted to the facility on 08/17/21 with diagnosis that include unspecified heart failure, unspecified dementia without behavioral disturbance, unspecified protein-calorie malnutrition, and Stage III pressure ulcer of sacral region.

Review of R61's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 03/02/22, Section G,, Functional Status G0110, Activities of Daily Living (ADL) Assistance H. Eating (how residents eats and drinks), R61 requires supervision (oversite, encouragement, or cueing) and one person physical assistance. Under ADL Assistance A. Bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture), R61 requires extensive

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F 677	Continued From page 6	F 677		

assistance (resident involved in activity, staff provide weight-bearing support) and two or more person physical assistance.

On 03/30/22 at 08:45 AM interview with R61's wife, stated R61 needs assistance with his meals.

On 03/31/22 at 08:16 AM, from outside of R61's bed room, R61 is heard yelling " ...help me, help me ..." R61 was observed lying in his bed yelling " ...help me, help me...I can't breathe ...I want to eat and I want to get out of here ..." R61's breakfast tray was observed to be uncovered on the tray table located on the side of R61's bed, out of reach. This surveyor assisted R61 with his call light. At 08:18 AM Infection Preventionist (IP) responded to R61's call light and R61 proceeded to inform IP that he wanted to eat and couldn't breathe. At 08:42 AM, observed R61 lying in bed and had not eaten his breakfast. At 08:44 AM, observed Certified Nursing Assistant (CNA) 19 request assistance from another CNA to position R61 to eat breakfast. R61 waited more than 28 minutes for staff to assist with his breakfast.

On 03/31/22 at 08:47 AM, observation and interview with CNA19 assisting R61 with his breakfast. CNA19 stated R61 needs staff to set-up his meal tray and is encouraged to eat independently with supervision. CNA19 further stated R61 is not feeling well today so he needs more assistance with eating but usually can feed himself. Inquired if R61 would be able to reach his food tray if it was on the side of his bed, CNA19 specified someone would have to bring the tray table to him. CNA19 stated she brought R61 breakfast tray to his room a little past 8:00 AM.

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F 677	Continued From page 7 On 03/31/22 at 12:56 PM, observed R61 awake lying down in his room, R61's covered lunch tray was on his tray table on the side of his bed, out of reach. Inquired if R61 ate his lunch, R61 stated he did not and needs help getting up. At 12:57 PM observed CNA19 assisting another resident with lunch. At 01:07 PM observed CNA19 go in R61's room. At 01:11 PM observed and interviewed CNA19, physically assisting R61 with his lunch. CNA19 stated the lunch trays arrived at around 12:35 PM. On 04/01/22 at 12:16 PM, interview and concurrent review of R61's medical chart. MDS Director confirmed R61 needs " ...mostly supervision with set up help but there are instances someone provides physical assist.... he had a recent significant change and a decline ...is mostly dependent in his eating with one person assist ..." MDS Director explained staff should first provide set up assistance and if they notice the resident needs more assistance to follow-up and provide further assistance needed. Inquired if staff should put the food trays in residents' room without set-up assistance if needed, MDS Director stated she believed if staff know a resident needs assistance with meals when the tray is taken to the resident's room staff should already be setting up and assisting. Further inquired the maximum amount of time after a meal tray is brought to a resident's room should staff assist with meals, MDS Director stated "Not sure if it's policy...10 minutes or so..."	F 677		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		5/2/22

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F 689	Continued From page 8 §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, staff interviews, and review of policy the facility failed to identify potential accident hazards from an unsecured Utility Room located in the hallway near the front Nurse Station. As a result of this deficient practice, the facility put the safety and well-being of the residents at risk for accident hazards. Findings include: An observation on 03/29/22 at 10:00 AM of the Utility Room located in the hallway near the front Nurse Station, noted the key to unlock the room door hanging on a string next to the door. Staff members used that key to enter the room. There was a sign outside the room that read Utility Room/Biohazard Waste. On 03/30/22 at 09:30 AM, Resident (R) 12 and other residents/family was seen outside the Utility Room. There were no staff members nearby to prevent or stop R12 and/or other residents/family from using the key to enter the room. During staff interview on 03/30/22 at 10:30 AM the Maintenance Supervisor (Maint) stated that the key was placed there so staff could easily access the room. Maint acknowledged that anyone else beside staff could also access the room. An observation of the room, along with Maint revealed the room stored the following	F 689	Facility replaced door knob with a keypad to validate that utility/ biohazard room is secure and not accessible to residents and visitors on 4/18/22 Residents residing in facility have the potential to be affected by this practice. Administrator/ designee educated staff on importance of securing utility/ biohazard room. Secure area in facility was inspected to validate there is a keypad and room is inaccessible to residents and visitors Maintenance/designee will complete 5 audits weekly X4 weeks then 5 audits monthly X2 months to validate that utility/ biohazard room is secure and not accessible to residents and visitors. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 689	Continued From page 9 cleaning/drug disposal chemicals: Peroxide multi surface cleaner and disinfectant, Drug Buster drug disposal system, Virex II 256 One step disinfectant cleaner and deodorant. During staff interview on 03/30/22 at 11:30 AM the Director of Nursing (DON) acknowledged that residents and/or residents/family could have access to the Utility Room and have access to the cleaning/drug disposal chemicals. Review of facility policy on Quality of Care Accident Hazards, Supervision, Devices stated the following: Purpose, to provide an environment that is free from controllable accident hazards and provision of supervision and devices needed to prevent avoidable accidents. Policy, the facility will provide an environment that is as free of accident hazards as is possible and provide supervision and assistance devices to residents to avoid preventable accidents. Guidelines, 9a. Identification of potential hazards in the resident environment and the risk of a resident having an avoidable accident ..., Risk and Environmental Hazards, 1. In order to be considered hazardous, a potentially hazardous item or situation must be accessible to a vulnerable resident ..., Physical Plant Hazards, 1. Potentially hazardous materials will be contained, to the extent possible, to protect residents from exposure, 2. Potentially hazardous materials include, but are not limited to: a. Chemicals used by facility staff in the course of their duties, or brought into the resident environment by staff, other residents or visitors.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		5/2/22

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F 760	Continued From page 10 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure medication was administered as ordered. Resident (R)24 had two physician orders of Acetaminophen for pain management. The physician orders specified that R24 should not receive more than 3 grams (g) of acetaminophen in a 24-hour period, but R24 was administered more than 3 g in a 24-hour period. As a result of this deficiency, R24 is at risk for further complications and potential harm. Findings include: During an interview with R24 on 03/29/22 at 09:40 AM, the resident reported having a headache to this surveyor. At 2:50 PM, this surveyor conducted a review of R24's Medication Administration Record (MAR). The MAR documented two orders for Acetaminophen for pain management: Tylenol (Acetaminophen) tablet, give 650 mg by mouth every 4 hours as needed for pain; Do not exceed 3 grams in 24 hours notify MD if ineffective. The physician's order was started on 1/20/22 at 6:30 PM and held on 03/19/22 at 4:30 PM to 3/26/22 at 4:29 PM. Acetaminophen 500 mg (milligrams), give 2 tablets (1000 mg) by mouth three times a day for pain for 7 days. This order was started on 3/19/22 at 4:00 PM. Review of the MAR documented on 03/26/22, R24 received Acetaminophen 1000 mg at 08:00	F 760	R24□s medical chart was completed and resident no longer resides at the facility. DON/Designee completed a baseline audit for current residents on 4/6/22 to validate that Tylenol/Acetaminophen orders do not exceed 3g. DON/ designee initiated further education to Licensed Nurses on 4/22/22 regarding maximum dosing of Tylenol/Acetaminophen DON/designee will complete 5 audits weekly X4 weeks then 5 audits monthly X2 months to validate that Tylenol orders do not exceed maximum dosage of 3g in a 24hr period. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 760	Continued From page 11 AM,12:00 PM; and Acetaminophen 650 mg at 5:23 PM, 11:30 PM which is a total of 3.3 grams within a 24-hour period. During a concurrent record review and interview on 04/01/22 at 11:10 AM, the Regional Nurse Consultant, Director of Nursing, and the Infection Preventionist confirmed R24 received more than 3 grams of Acetaminophen in a 24-hour period on 03/26/22.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		5/2/22

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	125020	A. BUILDING _____ B. WING _____	04/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	1930 KAMEHAMEHA IV RD HONOLULU, HI 96819

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F 761	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, review of the facility's policy and procedures, and interview with staff members, the facility failed to ensure two of five medication carts were kept locked or under direct observation of authorized staff. No medications were taken by residents but the potential for more than minimal harm exists. Findings Include: On 03/30/22 at 08:16 AM, observed a medication cart located at Lehua Unit unlocked without authorized staff in direct observation of the medication cart. Observed Resident (R) 48 sitting in his wheelchair next to the unlocked medication cart. At 08:18 AM this surveyor was able to open two of the drawers filled with residents' medications when Registered Nurse (RN) 21 approached the medication cart. Inquired with RN21 if the medication cart should be unlocked and unattended, RN21 stated it should be locked. At 08:20 AM observed RN8, the assigned staff member to the medication cart, return to the unlocked medication cart. On 04/01/22 at 08:29 AM, observed a medication cart located next to Nurse Station 1 at the Ho'opomomo Unit unlocked without authorized staff in direct observation of the medication cart. The unit is located on the second floor and in the front, nearby the elevators, the main dining room, and the access hallway to the other units. It is heavy trafficked with residents, staff members, and visitors passing by. At 08:30 AM observed Registered Nurse (RN) 20 return to the unlocked medication cart. Inquired with RN20 if the medication cart should have been locked, RN20	F 761	RN20 and RN8 were re-educated by the DON/Designee on 4/18/22 regarding keeping medication carts locked No residents were affected by this practice. DON/ designee initiated further education for licensed nursing staff regarding locking medication carts on 4/22/22. DON/designee will complete 5 weekly X4 weeks then 5 audits monthly X2 months to validate that medication carts are locked Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 761	Continued From page 13 stated she accidentally left it unlocked after quickly helping another resident in distress. The medication cart lock was observed to be a push lock. On 04/01/22 at 09:37 AM, interviewed Director of Nursing, medication cart is to be locked when staff member is away from their assigned medication cart but stated it is acceptable for staff member to ask another staff member to watch the medication cart " ...real quick ..." Review of the facility's policy and procedure "PHARMACY SERVICES Labeling and Storage of Drugs and Biologicals" dated 11/2017, "The facility stores drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys."	F 761		
F 880 SS=E	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: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		5/2/22

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F 880	Continued From page 14	F 880		

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.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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F 880	Continued From page 15 §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 record review, the facility failed to ensure infection control practices were implemented to help prevent the development and transmission of communicable diseases and infections. Family members were not wearing the appropriate Personal Protective Equipment (PPEs) while visiting a newly admitted resident on droplet precautions. Staff did not wear the appropriate PPEs when handling used gowns for a resident on droplet precautions. As a result of this deficiency, residents were at risk for transmission of communicable disease and infections. Findings include: 1) On 03/29/22 at 11:10 AM, observed a bin of PPEs and signage posted outside of Resident (R)178's room for contact and droplet precautions. In the room, three family members were visiting with R178. All three-family member wore cloth mask and R178 was not wearing any PPEs. Family Member (FM)1 was observed in direct contact with R178's arm and bedding. On 03/29/22 at 11:17 AM, conducted an interview and concurrent observation of R178's family members with the Director of Nursing (DON) and	F 880	Visitation guidelines were updated and are distributed to visitors upon arrival. No residents were affected by this practice. DON/Designee initiated further education to Nursing staff on 4/22/22 regarding facility visitation guidelines, infection control practices, hand hygiene and PPE usage DON/designee will complete 5 audits weekly X4 weeks then 5 audits monthly X2 months to validate that appropriate PPE is being utilized by visitors and staff members and sound infection control practices are in place. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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F 880	Continued From page 16	F 880		

the Infection Preventionist (IP). The DON and IP both confirmed R178's family members were not wearing the appropriate PPEs during the visit to be incompliance with contact and droplet precautions. Inquired with the DON and IP regarding how the facility was ensuring visitors were educated on the appropriate PPEs to wear while visiting and how they were ensuring visitors were compliant with wearing the appropriate PPEs correctly. The DON stated the facility's current process is for visitors are to check in at the front desk (downstairs on the first floor) where they are screened, then they go to the rooms by themselves. The IP stated that if staff observe visitors not wearing the appropriate PPEs, then visitors should be educated. The IP and DON confirmed that there is the potential of the visitors or residents being exposed to communicable disease and/or infection if visitors are not wearing the appropriate PPEs at the beginning and through the entirety of the visit. The DON confirmed the facility's current system for addressing PPE usage by visitors needs to be reviewed for the safety of visitors and residents.

On 03/30/22 at 3:30 PM, a record review of R178's Electronic Medical Record (EMR) documented R178 was on droplet precautions due to being newly admitted (on 03/23/22) for observation of signs and symptoms of COVID-19.

2) On 03/29/22 at 12:46 PM, observed Certified Nurse Aide (CNA)70 emptying a trash receptacle with used gown, outside Room 114. CNA70 attempted to tie the bag of used gowns, but it was too full. CNA70 attempted to tie the bag of used gowns closed, but the bag was too full. CNA70 pushed down on the used gowns with his/her hand and came into direct contact with the used

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F 880	Continued From page 17 gowns because CNA70 was not wearing gloves. After CNA70 tied the bag he/she proceeded to enter the room with the laundry chute without performing hand hygiene after direct contact with the used gowns. Droplet precaution signs were posted outside of Room 114 and CNA70 confirmed the bag of used gowns was used while providing care for the resident in Room 114 who was on droplet precautions. On 04/01/22 at 11:08 AM, conducted an interview with the Regional Nurse Consultant, DON, and IP it was confirmed that staff should not have touched the used gowns with his/her bare hands and should have been wearing gloves.	F 880		

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E 000	Initial Comments The facility was in compliance with the Health Section of §483.73, Requirements for Long Term Care Facility, Appendix Z, Emergency Preparedness.	E 000		

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

Electronically Signed | 04/22/2022

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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K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: K-281 Illumination of the Means of Egress This STANDARD is not met as evidenced by: Based on observation and staff interview with staff, the facility failed to provide lighting in the path of egress to a public way in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 7.8.1.1 and 7.8.1.2. This deficiency could affect all residents, staff, and visitors during an emergency requiring facility evacuation. Findings include: During facility survey on 3/31/22 at approximately 2:15 pm revealed that the facility failed to provide lighting from the exit door to a public way in the north rear exit. These findings were verified at the exit conference with the facility manager and Administrator on 3/31/22 at 3:00 pm.	K 281	Facility installed adequate lighting that is built into the generator to the north rear exit Residents residing in facility have the potential to be affected by this practice. Administrator/ designee educated maintenance staff on requirements for illumination of means of egress Maintenance Director/designee will complete audits during weekly rounds X8 weeks to validate that exit lighting meets requirements. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained.	5/2/22
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		5/2/22

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K 345	Continued From page 1 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: K-345 Fire Alarm System-Testing and Maintenance This STANDARD is not met as evidenced by: Based on record review and observation of the fire alarm panel with facility manager, the facility failed to maintain the facility's fire alarm system in a fully operable condition in accordance with NFPA 70, National Electric Code, 2011 edition, NFPA 72 National Fire Alarm and Signaling Code, 2010 edition, NFPA 101, Life Safety Code, 2012 edition, section 9.6.1.2 through 9.6.1.5 This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an operable fire alarm system. Findings include: During facility observation on 3/31/22at approximately 2:15 pm revealed that the facility failed to address the issues causing a "trouble signal" on the fire alarm panel. A fire watch was immediately ordered while the trouble signal could be investigated and repaired. These findings were verified at the exit conference with the facility manager and Administrator on 3/31/22 at 3:00 pm.	K 345	A fire watch was completed until fire panel operations could be restored. Facility fixed the fire panel issue on 4/8/22. Residents residing in facility have the potential to be affected by this practice. Administrator/ designee educated maintenance staff on requirements for the fire alarm system, testing and maintenance Maintenance Director/designee will complete audits during weekly rounds x8 weeks to validate that fire panel is functioning normally. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained.	
K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated	K 531		5/2/22

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K 531	Continued From page 2 monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: K-531 Elevators This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the facility's elevators in accordance with NFPA 101, Life Safety Code, 2012 edition, section 9.4.6.1. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper fire fighter operations. Findings include: During record review on 3/31/22 at approximately 1:15 pm revealed that the facility failed to provide documentation for the annual elevator inspection. These findings were verified at the exit conference with the facility manager and Administrator on 3/31/22 at 3:00 pm.	K 531	Facility confirmed with elevator vendor that preventative maintenance services are being performed. Facility to receive monthly and per diem service reports moving forward Residents residing in facility have the potential to be affected by this practice. Administrator/ designee educated maintenance director on the importance of maintaining elevator service records Maintenance/designee will review vendor□s service reports monthly X3 months to validate that preventative maintenance services are being performed per regulatory standards. Administrator/designee will present findings at the regulatory standards. facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates	

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K 531	Continued From page 3	K 531	compliance is sustained.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: K-761 Maintenance, Inspection and testing-Doors This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual inspection for the fire doors in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, sections 5.2, and 5.2.3. This deficiency could affect all residents, staff, and visitors during a fire due to the lack of an annual inspection to ensure proper protection from fire and smoke extension within the facility. Findings include: During record review on 3/31/22 at approximately 1:15 pm revealed that the facility failed to provide documentation for the annual fire door inspection.	K 761	Fire door inspections were completed by certified personnel on 5/2/22. Door deficiencies were addressed and documentation is on file. Residents residing in facility have the potential to be affected by this practice Administrator/ designee educated maintenance director on the importance of maintaining inspection records and fire door inspections Maintenance/designee will inspect fire doors during weekly rounds x8 weeks to validate that door maintenance and inspection services are being performed	5/2/22

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K 761	Continued From page 4 These findings were verified at the exit conference with the facility manager and Administrator on 3/31/22 at 3:00 pm.	K 761	per regulatory standards. Administrator/designee will present findings at the regulatory standards. facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		5/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER - HONOLULU, LLC	**1930 KAMEHAMEHA IV RD** **HONOLULU, HI 96819**

(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
K 918	Continued From page 5 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: K-918 Electrical Systems-Essential Electric System Maintenance and Testing This STANDARD is not met as evidenced by: Based on record review and staff interview with facility manager, the facility failed to produce documentation for an annual testing of diesel fuel in accordance with NFPA 99 Healthcare Facilities Code, 2012 edition, section 6.5.4, and NFPA 110 Standard for Emergency and Standby Power Systems, 2010 edition, section 8.3.8. This deficiency could affect all residents, staff, and visitors during an interruption of grid power due to the lack of an annual diesel fuel test to ensure proper operation of the standby power system. Findings include: During record review on 3/31/22 at approximately 12:15 pm revealed that the facility failed to provide documentation for the annual diesel fuel test. These findings were verified at the exit conference with the facility manager and Administrator on 3/31/22 at 3:00 pm.	K 918	Fuel test sample was complete on 4/14/22 and facility is awaiting report from vendor Residents residing in facility have the potential to be affected by this practice. Administrator/ designee educated maintenance director regarding the importance of annual fuel test for generator Maintenance Director/designee will complete audits during weekly rounds x8 weeks to validate that building maintenance and routine tests are kept up to date on TELs system. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team validates compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. BUILDING _____ B. WING _____	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 000	Initial Comments THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.73, REQUIREMENT FOR LONG-TERM CARE (LTC) FACILITIES	E 000		

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

Electronically Signed | 04/22/2022

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.