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

(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
4 000	Initial Comments A relicensure survey was conducted by the Office of Health Care Assurance (OHCA). The facility was not in compliance with Title 11 Chapter 94.1. Survey Dates: 03/29/22 to 04/01/22 Survey Census: 96 Sample Size: 34	4 000		
4 149	11-94.1-39(b) Nursing services (b) Nursing services shall include but are not limited to the following: (1) A comprehensive nursing assessment of each resident and the development and implementation of a plan of care within five days of admission. The nursing plan of care shall be developed in conjunction with the physician's admission physical examination and initial orders. A nursing plan of care shall be integrated with an overall plan of care developed by an interdisciplinary team no later than the twenty- first day after, or simultaneously, with the initial interdisciplinary care plan conference; (2) Written nursing observations and summaries of the resident's status recorded, as appropriate, due to changes in the resident's condition, but no less than quarterly; and (3) Ongoing evaluation and monitoring of direct care staff to ensure quality resident care is provided. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the baseline care plan	4 149	R179□s baseline care plan has been updated to include a focus,	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: _____ 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

(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
4 149	Continued From page 1 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 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	4 149	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 Improvement meeting monthly until QAPI team recommends a lesser frequency.	

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

(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
4 149	Continued From page 2 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 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	4 149		

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

(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
4 149	Continued From page 3 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.	4 149		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs; (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when	4 153		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: _____ 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

(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
4 153	Continued From page 4 eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure two residents (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.	4 153	R61 no longer resides at the facility. R39 is receiving assistance with meals, as 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.	

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

(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
4 153	Continued From page 5 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 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	4 153		

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

(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
4 153	Continued From page 6 (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 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	4 153		

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

(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
4 153	Continued From page 7 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. 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	4 153		

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

(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
4 153	Continued From page 8 staff assist with meals, MDS Director stated "Not sure if it's policy...10 minutes or so..."	4 153		
4 185	11-94.1-46(b) Pharmaceutical services (b) A facility shall have a current pharmacy policy manual consistent with current pharmaceutical practices developed and approved by the pharmacist, medical director/medical advisor, and director of nursing that: (1) Includes policies and procedures, and defines the functions and responsibilities relating to pharmacy services, including the safe administration and handling of all drugs and self-administration of drugs. Policies and procedures shall include pharmacy functions and responsibilities, formulary, storage, administration, documentation, verbal and telephone orders, authorized personnel, recordkeeping, and disposal of drugs; (2) Is reviewed at least every two years and revised as necessary to keep abreast of current developments in overall drug usage; and (3) Has a drug recall procedure that can be readily implemented. This Statute is not met as evidenced by: Based on interviews, observations, record review, and review of policy and procedures, the facility failed to 1) 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	4 185	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.	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: _____ 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

(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
4 185	Continued From page 9 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, 2) 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: 1) 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 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	4 185	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.	

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

(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
4 185	Continued From page 10 3 grams of Acetaminophen in a 24-hour period on 03/26/22. 2) 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 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	4 185		

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

(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
4 185	Continued From page 11 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."	4 185		
4 203	11-94.1-53(a) Infection control (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste. This Statute 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	4 203	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	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: _____ 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

(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 12 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 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	4 203	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.	

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

(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 13 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 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.	4 203		
4 220	11-94.1-55(g) Housekeeping (g) All combustible, potentially hazardous, or poisonous agents used for the cleaning of the facility shall be stored in a secured and locked area. This Statute 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	4 220	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	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: _____ 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

(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
4 220	Continued From page 14 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 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	4 220	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.	

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

(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
4 220	Continued From page 15 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.	4 220		