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 ______	03/17/2023

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
F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on 03/17/23. The facility was found not to be in substantial compliance with 42 CFR 483, Subpart B. Complaint and a facility reported incident were investigated, Aspen Complaint and Incident Tracking (ACTS) #10131 and 10143. This facility was not in compliance with 42 CFR 483, Subpart B related to ACTS complaint #10131. Survey Dates: 03/14/23 to 03/17/23 Survey Census: 103 Sample Size: 21	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		5/1/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/14/2023

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.

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 ______	03/17/2023

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
F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with respect and dignity for seven (Resident (R) R38, R37, R67, R5, R76, R82, and R51) residents sampled. Staff member stood over R37, R38, and R51 while providing assistance during meals; staff members were speaking another language while providing care to R5 and outside of residents' rooms; after R76 followed up for a requested item with nursing staff, a nursing staff member stuck her tongue at R76 and a nursing staff offered R76 drinking water from a communal bathroom sink; and while a nursing staff member was providing assistance to R82, the nursing staff member did not communicate to her in a way that promoted a dignified existence.	F 550	Residents (R37), (R38), (R51 were assessed for concerns of/indicators for decrease in quality of life related to assist provided with meal intake; none was identified. These residents will have a chair/stool placed in room for staff to use while assisting with feeding by 5/1/23 Resident (R5) was assessed for concerns of/indicators for decrease in quality of life related to staff speaking another language; none was identified Residents (R76) and (R82) discharged from the facility. DON/designee to educate RN11 regarding resident rights by 5/1/23. Current residents have the potential to be affected by this practice. Audit will be	

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 ______	03/17/2023

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
F 550	Continued From page 2 Findings include: Review of the facility's policy and procedure number 557 "RESIDENT RIGHTS Respect and Dignity" documents "The resident has a right to be treated with respect and dignity." 1) On 03/14/23 at 12:46 PM, conducted an observation of R38 in the resident's room during lunch. Observed R38 in bed with the head of the bed (HOB) raised and the resident's lunch was on the bedside table. Certified Nursing Assistant (CNA)45 stood at R38's bedside, over the resident while assisting R38 with lunch. CNA36 entered the room, relieved CNA45 from assisting R38 with lunch, and remained standing at R38's bedside while assisting R38 with the remainder of lunch. The practice of being eye level with the resident while assisting the resident with meal(s)/care/communication creates a homelike environment and exemplifies a dignified environment and interaction with the residents. 2) On 03/17/23 at 07:57 AM, conducted an observation of R37 during breakfast service. R37 was in his/her assigned room, in bed with the HOB elevated. Observed CNA37 standing at R37's bedside while assisting the resident with breakfast. The practice of being eye level with the resident while assisting the resident with meal(s)/care/communication creates a homelike environment and exemplifies a dignified environment and interaction with the residents. 3) On 03/07/23, the State Agency (SA) received an anonymous complaint regarding facility staff members speaking staff's native language in patient-care areas causing residents' and their	F 550	completed of current residents to validate there is available seating for staff if resident requires assist with eating, staff are speaking in a language the resident understands, staff are communicating in a way that promotes a dignified existence and options for filtered water are offered. Administrator/designee will reeducate current nursing staff education regarding Resident's Rights and professionalism by 5/1/23. DON/designee will reeducate current nursing staff about assisting residents to dine at eye level by 5/1/23. DON/designee will reeducate current nursing staff about speaking in the resident's preferred language in patient care areas and to communicate in a way that promotes a dignified existence by 5/1/23. Dietary department will discuss filtered water options during food preference review and if filtered water preference is identified it will be added to plan of care by 5/1/23. Administrator/designee will attend Monthly Resident Council meetings x3 months to educate on Resident Rights with residents as well as monitor for resolution of any concerns that may arise during those meetings. Administrator/designee will interview 5 patients weekly x4 weeks then monthly x2 months. Any concerns about resident rights or dignity will be promptly addressed. 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 ______	03/17/2023

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
F 550	Continued From page 3 families to feel uncomfortable. On 03/14/23 at 09:16 AM, observed two staff members speaking their native language, not English, in the hallway outside of residents' rooms. On 03/14/23 at 01:47 PM, during an interview with R67, R5's roommate, observed R5's curtain drawn and overheard R5 refusing care, asking unidentified nursing staff members to leave and that he does not need to be changed. While nursing staff members were redirecting and talking to R5, offering him ice cream, the nursing staff members were also overhead speaking another language, not understood by R5, to each other. R67 stated staff members will sometimes speak their native language, not English, and feels uncomfortable because when they laugh he does not know if they are laughing or talking about him. Review of R5's Electronic Health Record documented R5's primary language as English. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/09/22 documents R5's Brief Interview for Mental Status (BIMS) score at a 7, severe cognitive impairment. On 03/15/23 at 11:16 AM, observed two staff members speaking their native language, not English, in the hallway outside of residents' rooms. Residents and visitors are observed to be outside of the hallway. 03/17/23 at 09:07 AM interview with Director of Nursing (DON) was done. DON confirmed staff	F 550		

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 ______	03/17/2023

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
F 550	Continued From page 4	F 550		

members should not be speaking another language a resident cannot understand in the facility. DON reported it is not treating the residents with dignity and respect.

4) R76 was admitted to the facility on 02/14/23 for short-term rehabilitation. Review of R76's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/23 documents R76's Brief Interview for Mental Status (BIMS) score at a 15, cognitively intact.

During an interview R76 on 03/15/23 at 08:40 AM, R76 could not recall the date the incident happened but reported Registered Nurse (RN) 11 stuck her tongue at her. R76 reported at approximately 11:00 PM, she felt itchy and requested from RN11 to bring her cream, while waiting R76 fell asleep. At approximately 03:00 AM, she reportedly asked RN11 again about the cream she requested, asked why RN11 did not bring it and was "grumbling" to RN11. R76 reported RN11 then stuck her tongue at her. R76 stated she felt disrespected.

During the interview, R76 further reported on a separate incident, R76 requested for a cup of water from Certified Nurse Aide (CNA) 37. R76 reportedly observed CNA37 bring a cup of ice and goes into the communal bathroom in R76's room and fills the cup with water from there. R76 inquired of the water provided was filtered and CNA37 reportedly told her it was. R76 stated she felt gross, disgusted, upset when CNA37 brought her the water from the bathroom. R76 could not recall the date of the incident.

On 03/17/23 at 09:07 AM, an interview with DON was done. DON stated it is inappropriate for staff

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 ______	03/17/2023

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
F 550	Continued From page 5	F 550		

members to stick their tongue out at a resident. DON stated she was aware of the incident with R76 and requested a statement from RN11 but had not received it. DON confirmed nursing staff members were not treating R76 with dignity and respect.

5) R82 was admitted to the facility on 02/24/23 for short-term rehabilitation. Review of R82's 5-day scheduled assessment, in the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/28/23 documents R82's Brief Interview for Mental Status (BIMS) score at a 15, cognitively intact.

During an interview with R82 on 03/14/23 at 10:19 AM, R82 reported when she was admitted to the facility, on 02/24/23, she was not strong enough to transfer and reposition herself and her bed did not have grab bars to help reposition herself. R82 reported during the weekend she was admitted a nursing staff member was assisting her with repositioning, R82 and the nursing staff member were struggling when the nursing staff member reportedly told R82 "you think it's easy for me." R82 stated she was shocked, upset, and felt disrespected.

Review of the facility's grievance form dated 02/27/23 for R82 filed by Administrator documents the incident "CNA told resident "you need to help me, you think it's easy for me" Friday, 2/24 approx. 5pm."

On 03/17/23 at 10:32 AM an interview with the Administrator was done. The administrator stated she is the Grievance Officer and spoke to R82 about the incident. Administrator reported R82 was not able to give her the specifics of the staff

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 ______	03/17/2023

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
F 550	Continued From page 6 member. Administrator confirmed the reported conversation between the staff member and R82 was inappropriate and was not treating R82 with dignity and respect. 6) On 03/14/23 at 12:51 PM, conducted an observation of R51 during lunch. R51 was in bed with lunch on a bedside table in front of the resident. Certified Nurse Aide (CNA)99 entered the room and began assisting the resident with lunch. CNA99 stood next to the bedside while assisting the resident with lunch. On 03/17/23 at 10:10 AM, conducted an interview with the unit manager (UM)3. UM3 confirmed staff should have been seated while assisting the resident with lunch to foster a homelike environment.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		5/1/23

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 ______	03/17/2023

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

F 578 Continued From page 7 — F 578

residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review (RR), the facility failed to ensure the right to formulate an Advance Directive and/or ensure follow-up discussions regarding Advance Directives for four of six residents (Resident (R)50, R56, R5, and R76) sampled. As a result of this deficient practice, these residents were placed at risk of not having their wishes honored for future health care decisions, should they become incapacitated. This deficient practice has the potential to affect all the residents at the facility.

Findings include:

Provider's Plan of Correction:

Resident (R5) was reviewed and determined incapacitated. Information provided to surrogate decision maker in writing related to formulation of advanced directives and form for completing surrogacy on 4/13/23.
Resident (R56) and (R76) discharged from the facility. Resident (R50) was provided with written information regarding advance directives and offered to formulate an advance directive.

Current residents who are in the facility have the potential to be affected by this

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 ______	03/17/2023

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
F 578	Continued From page 8	F 578		

1) On 03/14/23 at 11:49 AM, a review of Resident (R)50's electronic health record (EHR) noted no advance health care directive (AD) found, and no documentation that it had been discussed. What was documented was a Durable Power-of-Attorney (DPOA) for finances, but none for health care.

A review of the SS [Social Services] Quarterly & Annual Evaluation, completed on 02/11/22 noted the following:

"Advanced Directives?... Yes ... Description: Names a DPOA." AD documentation requested from Social Services.

On 03/16/23 at 02:16 PM, an interview was done with the Social Services Manager (SSM) in her office. The SSM stated she was not aware that the DPOA document obtained by the facility was for finances only. The SSM reported she would follow up on a DPOA for health care.

On 03/16/23 at 03:23 PM, the SSM entered the State Agency (SA) conference room and confirmed R50's DPOA for finances had been mistakenly identified as AD documentation by the facility.

2) On 03/15/23 at 10:05 AM, a review of R56's EHR noted no AD found, and no documentation that it had been discussed. AD documentation was requested from social services.

On 03/16/23 at 02:16 PM, an interview was done with the SSM in her office. The SSM confirmed that she could find no documentation that an AD had been discussed with R56 or his family representative.

practice.
Social services/designee will audit current residents to validate that residents have advanced directives in place or residents/responsible parties were provided written information about advanced directives by 5/1/23. Audit will be completed on residents with a BIMs >9 to identify individuals who are incapacitated, and facility will provide directive information and designated-surrogate to the representative by 5/1/23.

Administrator conducted education with Social Workers on 4/10/23 regarding requirement to provide written information to residents relating to their right to request, refuse, formulate an Advance Directive. Administrator will educate Social Workers regarding individuals who are incapacitated and facilities designated-surrogate form. Social workers will provide written information to newly admitted residents relating to formulating an advanced directive.

Administrator/designee will audit 5 new admissions weekly x4 weeks then monthly x2 months to validate current AHCD or educate about their right to formulate an Advance Directive. Administrator/designee will present findings at the facility□s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency. esser 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 ______	03/17/2023

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
F 578	Continued From page 9	F 578		

3) R5 was admitted to the facility on 09/07/22. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/09/22 documents R5's Brief Interview for Mental Status (BIMS) score at a 7, indicating severe cognitive impairment.

During review of R5's Electronic Health Record (EHR) on 03/14/23 at 04:10 PM, the AD was not found. Review of a progress note dated 12/15/22 from social services documents "Writer offered to create any advance directives/POLST but resident's ... [family member] ...declined at this time." Further review of R5's EHR, power of attorney and designated-surrogate form was not found indicating R5's family member as R5's representative of health care decisions.

On 03/16/23 at 10:10 AM, an interview with Social Services Manager (SSM) was done. SSM confirmed an AD for R5 was not on file. SSM reported if a resident does not have an AD and is unable to develop one then the facility will look at the resident's support system to designate a surrogate to help make decisions on the resident's behalf.

On 03/16/23 at 01:54 PM, during a second interview with SSM, based on documentation from the hospital R5 transferred from, R5's representative was the family member listed as the emergency contact. POA and/or a designated surrogate form was not obtained.

4) R76 was admitted to the facility on 02/14/23 for short-term rehabilitation. Review of R76's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/23

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 ______	03/17/2023

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
F 578	Continued From page 10	F 578		

documents R76's Brief Interview for Mental Status (BIMS) score at a 15, indicating the resident is cognitively intact.

On 03/16/23 at 08:37 AM, an interview with R76 was done. R76 reported the facility never talked to her about formulating an AD. R76 stated "They didn't ask for one, they were supposed to ..." and further stated she had one from the hospital she transferred from but did not give it to the facility because they did not ask."

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION DATE
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		5/1/23

§483.10(i) Safe Environment.
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are

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 ______	03/17/2023

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
F 584	Continued From page 11 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to assure a resident has the right to a sanitary and comfortable homelike environment for two of five residents (Resident (R) 76 and R67) sampled. R76 was not comfortable leaving a communal bathroom to go back to her bed due to staff putting unsanitary items on the walkway floor and the sound level in the room while R67 is resting. Findings include: 1) Centers for Medicare and Medicaid Services (CMS) defined homelike environment and sanitary in the State Operating Manual (SOM) Appendix PP, "A "homelike environment" is one that de-emphasizes the institutional character of the setting, to the extent possible ...A determination of "homelike" should include the resident's opinion of the living environment ..." and ""Sanitary" includes, but is not limited to, preventing the spread of disease-causing	F 584	Resident (R67) will have a sound dampening bumper installed on their closet and drawers to decrease the noise level by 5/1/23. Resident (R76) discharged from the facility. Current residents who are receiving services in the facility have the potential to be affected by this practice. Audit will be completed on residents with a BIMs >9 to identify others that may have concerns related to noise levels or sanitary conditions. Concerns (should any be identified) will be addressed and resolved by 5/1/23. DON/designee will educate staff regarding homelike environment (noise level, sanitary conditions i.e. soiled items directly on floor) by 5/1/23. Maintenance/designee will place sound dampening buffers/bumpers on identified	

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 ______	03/17/2023

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

F 584

Continued From page 12

organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in the completion of the activities of daily living."

R76 was admitted to the facility on 02/14/23 for short-term rehabilitation. Review of R76's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/23 documents R76's Brief Interview for Mental Status (BIMS) score at a 15, indicating the resident is cognitively intact.

On 03/15/23 at 08:18 AM, during an interview with R76 in her room, R76 reported she was stuck in the bathroom last night because staff was helping her roommate, R11, change her soiled personal briefs. Observed the bathroom in the back of the room next to R11's bed, to enter and exit the bathroom, the walkway is on the side of R11's bed and will need to pass by R11. R76 further reported R11 had made a bowel movement and nursing staff just threw the soiled items on the ground in the walkway, staff did not put the items in a plastic trash bag to prevent contamination. R76 reportedly saw bowel movement remnants on the floor and nursing staff did not sanitize the floor but just quickly wiped the floor. R76 stated she did not want to leave the bathroom due to not wanting to contaminate her wheelchair and feet. R76 stated she observed therapy staff, that was assisting another resident in the room, step in the contaminated area. The therapy staff did not clean or wipe her shoes while walking throughout the room or before leaving the room. R76 described feeling disgusted when she left the bathroom and had to cross over the

F 584

residents' closets and drawers to help with noise by 5/1/23.

Activities director/designee will attend Monthly Resident Council meetings x3 months to monitor resolution of noise and safe, clean, comfortable homelike environment concerns. Any additional concerns identified will be addressed immediately. Administrator/designee will interview 5 patients weekly x4 weeks then monthly x2 months. Any concerns about noise levels or sanitary conditions will be promptly addressed. Activities director/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 ____	03/17/2023

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
F 584	Continued From page 13	F 584		

contaminated area. R76 was baffled and questioned why staff did not put the soiled items in a bag instead of the floor and why staff did not sanitize the floor thoroughly knowing R76 had to pass through the contaminated area to get out of the bathroom.

On 03/17/23 at 09:07 AM, an interview with Director of Nursing (DON) was done. DON stated while nursing staff is changing a resident after making a bowel movement the staff should discard the soiled linen and items directly in a trash bin or a trash bag, DON confirmed staff should not be throwing the soiled linen and items on the floor.

2) On 03/16/23 at 12:28 PM, during an interview R67, the resident reported when nursing staff come in the room they sometimes make a lot of noise that includes slamming the closet and drawer doors all times of day. R67 stated the noise is particularly inconsiderate during the night and early morning, when the resident is sleeping or resting.

On 03/17/23 at 09:07 AM, conducted a concurrent record review and interview with DON was done. DON stated the furniture in the rooms is old and even when you try to close the doors softly, they will make a loud slam noise. DON confirmed the noise is loud and jarring. Concurrent review of R67's most recent MDS documents R67's BIMS score at a 15, indicating the resident is cognitively intact.

Review of the facility's policy and procedure number 584 "RESIDENT RIGHTS Safe, Clean and comfortable Environment" documents "The facility will maintain comfortable sound levels."

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 ______	03/17/2023

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
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure residents are free from abuse or deprived of services by staff, for three of four residents (Resident (R) 82, R11 and R76) sampled. The facility failed to respond to R82's call light timely; a nursing staff member turned off R11's call light multiple times without providing assistance; and a nursing staff member did not help R76 when she requested assistance. Findings include: Review of the facility's policy and procedure "FREEDOM FROM ABUSE, NEGLECT and EXPLOITATION" defines abuse as "The willful ...deprivation by an individual, including a caretaker, of foods or services that are necessary to attain or maintain physical, mental, and psychosocial; well-being ..." "Willful" is defined as "The individual must have acted deliberately, not	F 600	Residents (R82), (R11), (R76) discharged from the facility. Current residents who are receiving services in the facility have the potential to be affected by this practice. Audit will be completed on residents with a BIMs >9 to validate resident care needs are met in a timely manner. Any concerns (should they be identified) will be resolved by 5/1/23. DON/designee will reeducate nursing staff regarding call light management and keeping residents free from abuse and neglect by 5/1/23. DON/designee will conduct 5 call light audits 5X a week x1 week, weekly x3	5/1/23

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 ______	03/17/2023

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
F 600	Continued From page 15	F 600		

that the individual must have intended to inflict injury or harm." The policy further documents the types of abuse including deprivation of goods and services, "Staff with the knowledge and ability to provide foods or services that are necessary for a resident to attain or maintain physical, mental, and psychosocial well-being but choose not to do it or to not acknowledge the request for assistance is a form of abuse."

1) During an interview with R82 and her roommate, R76, on 03/14/23 at 10:19 AM, R82 reported on 02/25/23 at approximately 10:30 PM she used her call light to call for nursing staff, R82 could not recall why she called the call light, but nursing staff did not come. R82 reported she attempted to press the call light a few more times with no results. At approximately 11:15 PM, the resident asked her roommate, R76, to activate the call light because staff did not respond to her call light and the call light may not be working. R82 reported to this surveyor and R76 confirmed staff did not come to the room in response to both R82 and R76, activating their call lights. R82 reported after staff did not come to the room when she activated the call light, the resident used her personal cellphone and called the facility approximately three times and staff did not answer the phone. At approximately 12:00 AM, R82 was able to reach staff via her cellphone. Staff then went to R82's room and informed the resident that her call light must be broken, and staff was unaware that she was trying to get ahold of staff. R82 informed this surveyor that she later found out her call light was working properly when she was using it to call staff and it was the adjacent room's call light that was not working properly.

weeks, monthly x1 month. Administrator/designee will interview 5 patients weekly x4 weeks then monthly x2 months. Any concerns relating to call light response will be promptly addressed. DON/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 ______	03/17/2023

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
F 600	Continued From page 16 Review of R82's records documented R82 was admitted to the facility on 02/24/23 for short-term rehabilitation. Review of R82's 5-day scheduled assessment, in the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/28/23 documents R82's Brief Interview for Mental Status (BIMS) score at a 15, documenting the resident is cognitively intact. On 03/17/23 at 09:07 AM an interview with Director of Nursing (DON) was done. DON stated she recalled the incident but does not believe R82's call light was broken. On 03/17/23 at 10:32 AM an interview with the Administrator was done. The Administrator confirmed R82's call light was functioning properly and stated if a staff member is unable to respond to a resident timely staff should ensure someone checks on the resident to ensure it is not an emergency, then staff should inform the resident they are assisting another resident and will assist them as soon as possible. 2) On 03/16/23 at 08:37 AM interview with R76 was done. R76 reported that R11, her roommate, was verbally calling out for nursing staff last night (03/15/23) and in response R76 used her call light. R76 reported seeing Registered Nurse (RN) 11 turned off the call light without entering the room and checking who called. R76 reported she pressed the call light two more times and RN11 continued to turn off the call light and only entered the room after the third time. R76 stated she does not understand why RN11 could not just go inside the room and check who was requesting for assistance before turning off the call light and leaving. R76 reported R11 needed medicine for her cough.	F 600		

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 ______	03/17/2023

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
F 600	Continued From page 17	F 600		

R76 was admitted to the facility on 02/14/23 for short-term rehabilitation. Review of R76's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/23 documents R76's Brief Interview for Mental Status (BIMS) score at a 15, indicating the resident is cognitively intact.

R11 was admitted to the facility on 01/24/23. Review of R11's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/23 documents R11's Brief Interview for Mental Status (BIMS) score at a 09, indicating the resident is moderately cognitive impairment.

On 03/17/23 at 09:07 AM an interview with DON was done. DON stated staff should be answering call lights and identifying which resident needs assistance before leaving the room.

3) On 03/15/23 at 08:40 AM, an interview with R76 was done. R76 reported she could not recall the date, time, or staff member but while R76 was sitting in her wheelchair next to her bed, she asked a Certified Nurse Aide (CNA) for assistance while the CNA was helping R11 (R76 and R11 are roommates). The CNA reportedly told R76 she was not assigned to work with her and left the room without helping the resident. R76 observed the CNA talking with another staff member outside of the room and did not get another staff member to assist.

On 03/17/23 at 09:07 AM an interview with DON was done. DON confirmed it does not matter which rooms or which residents a nursing staff is

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 ______	03/17/2023

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
F 600	Continued From page 18 assigned to; all staff can assist any resident.	F 600		
F 623 SS=F	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		5/1/23

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 ______	03/17/2023

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
F 623	Continued From page 19	F 623		

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy

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 ______	03/17/2023

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
F 623	Continued From page 20 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to notify in writing the transfer and discharge to hospital as indicated in regulation for two of two residents (Resident (R)14 and R20) sampled. Findings include: 1. On 03/16/23 at 02:20 PM, conducted Record Review (RR) of Resident (R)14's Electronic Health Record (EHR). A Social Services note dated 03/07/23. Social Services Manager (SSM) documented resident emergency contact was informed via telephone of R14's discharged because the resident was transferred to an acute hospital. There was no documentation that a written notice was provided to R14's emergency contact.	F 623	Resident (R14) discharged from the facility. Resident (R20) was provided a Notice of Transfer/Discharge on 4/14/23. Current residents who require transfer or discharge have the potential to be affected by this practice. Administrator/designee will review patients who discharged from the facility in the past 14 days by 5/1/23 to validate that a Notice of Transfer/Discharge was completed. Social services were educated on 4/10/23 by Administrator regarding Notice of Transfer/Discharge to resident and/or responsible party in a timely manner.	

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 ______	03/17/2023

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
F 623	Continued From page 21 2. On 03/17/23 at 09:26 AM, conducted a concurrent RR and interview with facility administrator. She confirmed that the facility notifies residents, family, or representatives telephonically rather than providing written notifications of discharge. 2) Review of the EHR documented R20 was discharged to the hospital on 11/07/22 for sepsis and elevated troponin level. Further review did not show a notification in writing of the transfer and discharge to the resident and/or representative. During staff interview on 03/16/23 at 02:40 PM, Social Services Manager (SSM) acknowledged that the facility did not notify R20 and representative in writing of the transfer and discharge. SSM further revealed that the facility currently does not send a written notification of transfer and discharge to the resident and/or representative but will look at adding this to the process. Review of facility policy on Admission, Transfer & Discharge, Facility initiated transfers or discharges read the following: Policy, The facility will follow regulations governing the facility initiated transfer or discharge. Guidelines ... 8. Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language manner they understand.	F 623	Administrator/designee will audit 5 discharged patients weekly x4 weeks then monthly x2 months to validate that written notices of transfer and discharge are being issued in a timely manner. Administrator/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
F 625 SS=F	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		5/1/23

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 ______	03/17/2023

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
F 625	Continued From page 22 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and record review (RR), the facility failed to provide written notice of bed-hold policy as indicated in regulation for 2 of 2 Residents (R)14 and R20 sampled. Findings include: (Cross-Reference to F623 - Notice Requirements Before Transfer/ Discharge)	F 625	Resident (R14) discharged from the facility. A copy of the Bed hold policy was sent to resident on 4/14/23. Resident (R20) returned to the facility and was provided a copy of the Bed Hold policy on 4/14/23. Current residents who require transfer or discharge have the potential to be	

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 ______	03/17/2023

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
F 625	Continued From page 23 1) On 03/16/23 at 02:20 PM, conducted a RR of R14's Electronic Health Record (EHR). A Social Services note documented resident representative was verbally informed via telephone of the facility's bed-hold policy when resident was transported to an acute hospital. There was no documentation that a written notice was provided to the resident and/or resident's representative. On 03/17/23 at 09:26 AM, conducted a concurrent RR and interview with Administrator. The Administrator confirmed that residents and/or their representatives are notified via telephone regarding the facility's bed-hold policy, but currently the facility does not have a process for providing written notification of bed-hold policy the resident and/or their representatives. 2) Review of the EHR indicated that R20 was transferred to the hospital on 11/07/22 for sepsis and elevated troponin level. Further review did not show any written notice that specifies the duration of bed-hold policy to the resident and/or representative. During staff interview on 03/16/23 at 02:40 PM, Social Services Manager (SSM) acknowledged that the facility did not provide written notification of bed-hold policy to R20 and representative. SSM further revealed that the facility currently does not send a written notice which specifies duration of bed-hold policy to the resident and/or representative but will look at adding this to the process. Review of facility policy on Admission, Transfer & Discharge, notice of bed hold policy before/upon transfer read the following: Policy, the facility will provide written information to the resident or	F 625	affected by this practice. Administrator/designee will review patients who discharged from the facility in the past 14 days by 5/1/23 to validate a written notice of bed hold policy was offered to resident/resident representative. Social services were educated by Administrator regarding Notice of Bed Hold Policy Before/Upon Transfer to resident and/or responsible party in a timely manner. Administrator/designee will audit 5 discharge patients weekly x4 weeks then monthly x2 months to validate that written notice of bed hold policy is provided in a timely manner. 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 ______	03/17/2023

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
F 625	Continued From page 24 resident representative specifying the duration of the state bed-hold policy, if any, during which time the resident is permitted to return and resume residence in the facility. The information will also include a) the reserve bed payment policy in the state plan; b) the facility's policies regarding bed-hold periods, and c) information related to the resident's ability to return to the facility. This information will be provided to the resident and the resident representative before a transfer or therapeutic leave and at the time of transfer of a resident for hospitalization or therapeutic leave.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		5/1/23

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 ______	03/17/2023

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
F 656	Continued From page 25 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement a person-centered Comprehensive Care Plan (CP) for three of five residents ((R)50, R8, and R77) sampled. As a result of this deficient practice, these residents were at risk of a decline in their quality of life, not attaining their highest practicable well-being, and the potential for serious harm and/or death due to adverse effects of an anticoagulant medication. This deficient practice has the potential to affect all the residents at the facility. Findings include: 1) Cross-reference to F676 Activities of Daily	F 656	R50's care plan was reviewed and updated to reflect current status on 4/6/23. R8's care plan was reviewed and updated to reflect current status on 3/17/23. Resident (R77) discharged from the facility on 3/17/23. Current residents with infections requiring isolation, residents with communication deficits and residents on anticoagulant therapy have the potential to be affected by this practice. Members of the IDT team will complete a comprehensive care plan review for current residents requiring isolation, residents with communication deficits and residents on anticoagulant	

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 ______	03/17/2023

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

F 656

Continued From page 26

Living (ADLs)/Maintain Abilities. The facility failed to provide the proper care and treatment to maintain the ADLs for Resident (R)50, including a care plan for scabies and social isolation due to having scabies. As a result, R50 experienced a decline in her ADL function.

2) Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities. The facility failed to provide the proper care and treatment to maintain/improve the communication abilities of R8, including a care plan for aphasia/communication. As a result, R8 was placed at an increased risk of not having her needs met.

3) Review of the Electronic Health Record (EHR) revealed that R77 was admitted on 2/16/23 with a diagnosis of End Stage Renal Disease, Paroxysmal Atrial Fibrillation, Hypertensive Heart Disease, Heart Failure ... The doctor's orders showed R77 was prescribed Eliquis 2.5 mg two times a day. A review of the most recent Comprehensive Care Plan did not have specific interventions to monitor for the possibility of bleeding due to taking Eliquis medication.

During a staff interview on 03/16/23 at 01:30 AM, the Director of Nursing (DON) acknowledged that there was no monitoring for possible bleeding listed in the Comprehensive Care Plan for R77.

Review of facility policy on Comprehensive Care Plans read the following: Purpose, to provide each resident with a person-centered comprehensive care plan to address the resident's medical, nursing, physical, mental, and psychosocial needs. Policy, the facility interdisciplinary team will develop and implement

F 656

therapy to validate their care plan promotes quality of life, attaining or maintaining highest practicable well-being and identifies/minimizes risk for adverse outcomes by 5/1/23.

DON/designee will educate clinical staff about comprehensive care plans for residents requiring isolation, residents with communication deficits and residents on anticoagulant therapy to validate their care plan promotes quality of life, attaining or maintaining highest practicable well-being and identifies/minimizes risk for adverse outcomes by 5/1/23.

DON/Designee will review 5 residents comprehensive care plans to validate residents requiring isolation, residents with communication deficits and residents on anticoagulant therapy have care plan that promotes quality of life, attaining or maintaining highest practicable well-being and identifies/minimizes risk for adverse outcomes, weekly x4 weeks and monthly x2 months. DON/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 ______	03/17/2023

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
F 656	Continued From page 27 a comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, physical, mental, and psychosocial needs that are identified in the comprehensive assessment.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		5/1/23

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 ______	03/17/2023

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
F 657	Continued From page 28 Based on observation, record review, and interview, the facility failed to ensure a resident's person-centered comprehensive Care Plan (CP) was reviewed and revised for one Resident ((R)50) sampled. As a result of this deficient practice, staff did not have the information necessary to adequately care for R50 ensuring the resident meets the highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: Cross-reference to F676 Activities of Daily Living (ADLs)/Maintain Abilities. The facility failed to provide the proper care and treatment to maintain the ADLs for Resident (R)50, including revising her activities and ADL care plans after identifying, isolating, and treating her for scabies. As a result, R50 experienced a decline in her ADL function. In addition, despite a functional decline being recently identified and referred to a Physical Therapist (PT), no revisions in R50's ADL CP had been done as a result.	F 657	Resident (R50) care plan was reviewed and updated on 4/6/23 to reflect current condition. Current residents that experience changes in condition are at risk of failed practice. Members of the IDT team will complete care plan review for current residents that have experienced a change in condition that requires care plan revision. Care plans will be revised to reflect current conditions and interventions implemented by 5/1/23. DON/designee will educate nursing staff about updating care plans with resident condition changes by 5/1/23. DON/Designee will review 5 care plans to validate residents with condition changes have care plan revisions to reflect current status. Audits will be done weekly x4 weeks and monthly x2 months. DON/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate	F 676		5/1/23

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 ______	03/17/2023

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
F 676	Continued From page 29 that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide the proper care and treatment to maintain the activities of daily living (ADLs) for Resident (R)50. In addition, the facility failed to provide the proper care and treatment, including assistive devices, to improve the communication abilities of R8. As a result, R50 experienced a decline in her ADL	F 676	R50 scabies infection resolved on 1/30/23 and contact precaution isolation was discontinued that same day. R50 is currently receiving therapy services to improve ADL capabilities. A communication book was placed at the bedside and with wheelchair on 3/17/23 so resident will have a communication	

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 ______	03/17/2023

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

F 676 Continued From page 30

function and R8 was placed at an increased risk of not having her needs met. Both residents were placed at risk of experiencing a decline in their physical well-being, psychosocial well-being, and quality of life. This deficient practice has the potential to affect all residents at the facility placed on isolation in their rooms and/or with communication needs.

Findings include:

1) Resident (R)50 is a 52-year-old female admitted to the facility on 01/07/21 following a stroke.

On 03/14/23 at 12:08 PM, an observation was done of a Physical Therapist (PT) in R50's room conducting an evaluation of her.

During an interview with R50 on 03/14/23 at 01:48 PM at her bedside, R50 reported that the PT had evaluated her because she had experienced a decline in her ADLs following a period of time at the end of January where she had been isolated in her room "for 14 days," after being told that she had scabies. R50 stated that during that time, she had no therapy, no restorative care, no activities, and when she asked for help transferring out of bed to her wheelchair, she was told by staff that she had to remain in bed because of the scabies. As a result, R50 reported that she got weaker and could no longer do as many of the things that she was able to do before she was isolated for scabies.

On 03/17/23 at 07:44 AM, a record review (RR) was done of R50's electronic health record (EHR). The RR revealed a PT Evaluation & Plan

F 676

book readily accessible. Resident demonstrated proper use of the book on 4/20/23. R8's care plan was revised on 3/17/23 to include aphasia and use of communication book.

Current residents who have been on isolation precautions in the past 30 days or have a diagnosis of aphasia have the potential to be affected by this practice. Infection Preventionist/designee will conduct facility wide audit of residents who have been on isolation precautions in the past 30 days by 5/1/23 to assess for ADL decline.
Director of Nursing/designee will ensure residents with aphasia have been evaluated by SLP as appropriate for optimal communication strategies by 5/1/23.

DON/designee will reeducate nursing staff on practices to maintain resident ADL capabilities while on isolation by 5/1/23.
Facility will review scabies protocol and educate clinical staff that activities to maintain ADLs (therapy services, activities, getting up out of bed) are to be continued as normal while adhering to isolation guidelines by 5/1/23.
DON/designee will reeducate nursing staff on using alternate communication methods for residents with aphasia as per SLP recommendation by 5/1/23.
Infection Preventionist/designee will monitor residents on isolation for ADL decline.

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 ______	03/17/2023

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
F 676	Continued From page 31 of Treatment note from 03/14/23 reporting that the evaluation referral to PT was done "by nursing due to decline in functional mobility," with a PT finding of "Clinical Impressions: Pt [patient] demonstrates decline in Ambulation compared to prior level of function." It also confirmed a 03/13/23 physician order for a "PT eval [evaluation] for decline in mobility." A review of R50's nursing progress notes confirmed she was diagnosed with scabies, isolated to her room, and placed on contact precautions on 01/20/23. A review of R50's comprehensive care plan (CP) noted no care plan was developed for scabies, or her social isolation as a result of scabies. There were also no revisions noted in her activities CP or her ADL CP as a result of the scabies diagnosis, treatment, or isolation. It was also noted that despite a functional decline being identified and referred to a PT, no revisions in R50's ADL CP had been done as a result. On 03/17/23 at 08:05 AM, an interview was done with the Director of Nursing (DON) in the facility Conference Room/OT Office. The DON confirmed that the facility protocol for scabies does include isolating the resident for 14 days. When asked about getting R50 up out of bed in her room during isolation to help maintain her mobility, the DON could not explain why that would not have occurred. The DON also could not explain the lack of a CP for scabies but reported that she would expect to see one. The DON checked to see if the CP had been resolved and that is why it was not showing up during record review, but she did not find a resolved CP for scabies either.	F 676	Infection Preventionist/designee will conduct random audits on 5 residents who are on isolation to validate ADL status is maintained. Audits will be done weekly x4 weeks, and monthly x2 months. Director of Nursing/designee will conduct random audits on 2 residents with aphasia to validate communication needs are being met. Audits will be done weekly x4 weeks and monthly x2 months. Director of Nursing/designee and Infection Preventionist/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 ______	03/17/2023

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
F 676	Continued From page 32 2) R8 is a 75-year-old female admitted to the facility on 01/02/23 following a stroke, with one of her admitting diagnoses being aphasia (a disorder affecting a person's ability to express and understand written and spoken language). On 03/14/23 at 02:15 PM, an interview was done with R8 at her bedside. Several times during the interview, R8 would stop speaking, either stuttering or at a complete loss of words, and express frustration and embarrassment that she could not finish what she was saying. Observations done at this time noted no communication systems/aides, such as a communication board, visible at the bedside. On 03/16/23 at 04:00 PM, a review of R8's EHR was done. A review of her comprehensive CP noted no CP developed for aphasia or communication despite the admitting diagnosis. On 03/17/23 at 08:22 AM, an interview was done with the DON in the facility Conference Room/OT Office. The DON stated that she would expect to see a CP for aphasia and could not understand why one was not initiated. The DON reported that R8 should have a communication binder/picture book at her bedside to aid her communication. When told that it was not observed by the State Agency, the DON stated that she would follow-up on it.	F 676		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		5/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125020	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 03/17/2023
NAME OF PROVIDER OR SUPPLIER: AVALON CARE CENTER - HONOLULU, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 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
F 689	Continued From page 33 §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 interviews and record review, the facility failed to ensure a resident was free of accident hazards for one of two residents sampled (Resident (R) 27). As a result of this deficient practice, the resident is at risk for potential harm. Findings include: R27 was admitted to the facility on 10/06/22. Review of R27's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/12/23 documents R27's Brief Interview for Mental Status (BIMS) score at a 15, indicating the resident is cognitively intact. On 03/16/23 at 08:27 AM an interview with R27 was done. R27 stated he had a recent fall in the shower. R27 reported he sat on a previously known uneven and shaky shower chair when the shower chair broke, and he fell in the shower. R27 stated Certified Nurse Aide (CNA)31 witnessed the fall and was assisting him with showering. Review of R27's nursing note documents on 03/11/23, "Today is resident's shower schedule. Co-RNs [Registered Nurses] heard a loud noise. The shower room was checked and found resident on the sitting on broken standard shower chair. As per CNA and resident, shower chair	F 689	Broken shower chair was replaced on 3/11/23. Residents who receive require use of shower chair during showers in the facility have the potential to be affected by this practice. Maintenance Director/designee will audit all shower chairs to validate that they are in proper condition by 5/1/23. Administrator, DON will re-educate nursing staff by 5/1/23 to validate shower chair condition prior to each use and notify maintenance director if not in good condition. Maintenance Director will inspect shower chairs monthly to validate that they are in proper working condition. Maintenance director/designee will audit all shower chairs weekly x4 weeks, then monthly x 2 months to validate that they are in proper working condition. Monthly audits will be monitored through TELS. Maintenance director/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 ______	03/17/2023

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
F 689	Continued From page 34 broke ...Staff notified to use bariatric chair in the future." On 03/17/23 at 09:07 AM an interview with Director of Nursing (DON) was done. DON reported R27 has been using a regular shower chair with no issues but stated the shower chair he was using may have been old. Inquired who ensures the shower chairs are in safe and good condition, DON stated CNA staff should be checking shower chairs before using them to ensure they are in good working condition.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		5/1/23

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 ______	03/17/2023

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
F 726	Continued From page 35 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure nursing staff demonstrated competency skills for one resident (Resident (R)76). Staff did not competently apply a pain medication patch as ordered by the physician. As a result of this deficient practice, R76 is at risk of the potential for harm related to unrelieved pain. Findings include: R76 was admitted to the facility on 02/14/23 for short-term rehabilitation. Review of R76's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/19/23 documents R76's Brief Interview for Mental Status (BIMS) score at a 15, cognitively intact. On 03/14/23 at 10:25 AM during an interview with R76 and her roommate in their room, R76 was called by nursing staff members to come outside of the room, R76 was observed to have two long vertical incisions down both her knees with no bandage wrapped around them during the interview. R76 was then observed to be in front of the room door facing the hallway receiving care by nursing staff. R76 could be heard raising her voice about a patch not supposed to be on her incisions. At 10:29 AM, R76 returned to the interview and both her knees were observed to	F 726	Resident (R76) discharged from the facility. Residents who are receiving topical patches have the potential to be affected. Residents with topical patch medication will have orders reviewed to validate patches are being applied per physician orders by 5/1/23. DON/designee will reeducate LNs on application of topical patch per physician orders/instructions by 5/1/23. DON/designee will conduct random audits of topical patch medication orders on 3 residents weekly x4 weeks, then monthly x2 months to validate they are applied in a manner consistent with physician orders. DON/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 ______	03/17/2023

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
F 726	Continued From page 36 be bandaged. R76 stated Registered Nurse (RN) 20 is always rushing. R76 reported her physician instructed nursing staff to put pain patches on both sides of her incision and not on top of it. R76 further reported nursing staff had just put the pain patch on top of her incision, R76 took the patch off herself and needed to tell them it is not supposed to be there. R76 stated she was upset that nursing staff are not following the physician's order. Review of R76's Electronic Health Record (EHR) documents in the physician's order for Lidoderm Patch 5% (Lidocaine) "Apply to KNEES topically one time a day for PAIN *Apply 2 patches to painful areas *Do not place on any incisions. May cut patch in half to cover most painful areas. *ON for 12 hrs [hours], OFF for 12 hrs and remove per schedule" dated 02/28/23 and active 03/01/23. On 03/17/23 at 09:07AM concurrent record review and interview with Director of Nursing (DON) was done. DON confirmed the physician's order and instruction for R76's Lidocaine patch was for the patches not to places on the incisions. DON stated nursing staff should put Lidocaine patches on incisions because the skin area could get moist and cause skin breakdown.	F 726		
F 732 SS=E	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked	F 732		5/1/23

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 ______	03/17/2023

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
F 732	Continued From page 37 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview the facility failed to update the nurse staffing data daily. Findings include: On 03/16/23 at 08:59 AM observed the facility's nurse staff data posting dated 03/15/23, the day before.	F 732	No residents were identified. Staffing information was posted on 3/16 and thereafter. Current residents have the potential to be affected by this practice. Staffing information will be posted per F732 requirements.	

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 ______	03/17/2023

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
F 732	Continued From page 38 On 03/16/23 at 09:06 AM concurrent observation and interview with Wound Care Nurse (WCN), WCN confirmed the nurse staff data posted was dated the posting from yesterday, 03/15/23 and was not updated. On 03/17/23 at 09:01 AM observed the facility's nurse staff data posting dated 03/16/23, the day before. On 03/17/23 at 09:06 AM interview with Director of Nursing was done. DON stated the nurse staff data should be posted every morning by the scheduler, and if the scheduler is late then night shift or managers should be instructed to update the posting. DON stated, "there should be a new schedule up right now."	F 732	Administrator will re-educate nursing staff and staffing coordinator on the requirements for posting nurse staffing information by 5/1/23. Administrator/designee will audit the posted staffing information daily x 5 days for 4 weeks, then weekly 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.	
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	F 761		5/1/23

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 ______	03/17/2023

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
F 761	Continued From page 39 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were securely stored in locked compartments, and failed to ensure all medications used in the facility were labeled in accordance with professional standards. Proper security and labeling of medications is necessary to promote safe administration practices, decrease the risk for medication errors, and decrease the risk for the diversion of resident medications. This deficient practice has the potential to affect all residents in the facility who take medications. Findings include: 1) On 03/16/23 at 07:23 AM, observed Nursing Staff (NS)2 walk away from medication cart (med cart) 1A, leaving it unlocked. State Agency (SA) reminded her to lock it before walking to the other end of the hall to med cart 1B. At 07:23 AM, observed NS2 walk away from med cart 1B, leaving it unlocked outside room 114. SA again reminded her to secure her med cart before walking away. NS2 acknowledged that the facility practice is to always secure the med cart before leaving it unattended.	F 761	Nurse 2 was re-educated on locking medication carts when leaving cart unsupervised on 3/17/23. Resident (R87) is no longer at the facility. Insulin supply was discarded and replaced on 3/16/23. Residents on the unit with unlocked medication cart are potentially affected; there were no incidents of residents accessing an unlocked medication cart. Residents that receive insulin are potentially affected. DON/designee will audit insulin supply to validate appropriate labeling by 5/1/23. DON/designee will re-educate RN and LPN staff about proper labeling and storage of medications, including locking medication carts when unsupervised by 5/1/23. Pharmerica to provide ekit supply of insulin within Ziploc bags to prevent label from being displaced from insulin vial/pen. DON/designee will conduct random audits on 10 residents' insulin weekly x4 weeks, then monthly x2 months to validate that it is appropriately labeled and not used after expiration date.	

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 ______	03/17/2023

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
F 761	Continued From page 40 At 07:29 AM and 07:54 AM, observed NS2 walk away from med cart 1B, leaving it unlocked outside room 114. From 07:38 AM to 07:42 AM, observed NS2 leave medications she had poured for Resident (R)13 unsecured on the top of med cart 1B as she entered room 114 to administer medications to Resident (R)56. At 12:00 PM, returned to med cart 1B to question NS2 and found the med cart unlocked and unattended with no staff in sight. 2) On 03/16/23 at 12:14 PM, during an inspection of med cart 1B, observed a vial of insulin aspart with no visible emergency kit (EKIT) or pharmacy label on either the vial or the box. Facility label on the box did specify to discard 28 days after opening, and indicated that it had been opened on 02/15/23 with a date to discard of 03/15/23. Written in black permanent marker on the box was Resident (R)87's last name. At 12:31 PM, interviewed NS2 in front of med cart 1B. NS2 confirmed that the insulin aspart order is for 6 units three times a day and verified that she did give R87 his morning and lunchtime dose from the vial found in med cart 1B. NS2 also confirmed that she was not aware that the date to discard was yesterday, and acknowledged that she had failed to check the discard date prior to administering the medication. At 12:43 PM, interviewed Registered Nurse, Unit Director (UD)1, at the Station 1 nurses' station. When asked about the procedure for labeling insulin, UD1 confirmed that either the insulin vial or the box should have a pharmacy label with the	F 761	DON/designee will conduct random audits to validate medication carts are locked when unattended. Audits will be completed weekly x 4 weeks then monthly x 2 months DON/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 ______	03/17/2023

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
F 761	Continued From page 41 resident's full name, medication name, and dosage, or it should have an EKIT label with the resident's full name. UD1 agreed that writing R87's last name only was not an adequate resident identifier since it is not uncommon for there to be multiple residents admitted with the same last name. At 01:58 PM, a second interview was done with UD1 at the Station 1 nurses' station. UD1 confirmed that because R87 was discharged from the facility on 02/24/23 (then subsequently readmitted on 02/28/23), they should have discarded the vial of insulin aspart at discharge, then opened a new vial if and when the resident was readmitted. UD1 could not explain why the proper procedure had not been followed. 3) On 03/15/23 at 10:53 AM, observed a med cart 1A located next to Nurse Station 1 unlocked without authorized staff in direct observation of the medication cart. The med cart was 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 10:56 AM observed Registered Nurse (RN) 25 return to the unlocked medication cart. Inquired with RN25 if the medication cart should have been locked, RN25 confirmed it should have been locked.	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		5/1/23

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 ______	03/17/2023

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
F 804	Continued From page 42 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food was palatable, attractive, and at an appetizing temperature for two residents (Resident (R)51 and R54). As a result of this deficient practice, residents are at risk for the potential of negative psychosocial and/or a decline in weight. Findings include: On 03/14/23 at 12:34 PM, conducted an observation of R51's and R54's lunch and concurrent interviews with both residents. R51 looked at her food and inquired with this surveyor if her lunched looked good enough to eat? This surveyor inquired with the resident if she thought it looked good to eat? R51 stated that the food does not look good and it makes her not want to eat it. R51 reported that her food often comes cold because they (R51 and R54) are one of the last rooms to receive their food. R51 stated that the food often does not look appetizing. R54 confirmed with R51 in that the food often does not look appetizing and the hot food is not always hot. R54 stated that she likes to have butter in her oatmeal, however, she when she received the oatmeal it was not hot and the butter did not melt when she stirred it into the oatmeal. R54 reported feeling "down" because she enjoys eating melted butter in her oatmeal.	F 804	Dietitian/designee met with residents R51 and R54 to discuss preferences on 3/16/23. Current residents have the potential to be affected by this practice. Dietary manager/designer will interview residents who eat in their room to validate that meal temps are satisfactory. Residents will be given the option to eat in the main dining room or have meals reheated upon request. DON/ designee will reeducate staff regarding the importance of serving food in a timely manner so that meals are at the appropriate temperature when served by 5/1/23. Facility ordered a new new plate warmer on 2/22/23 and is awaiting delivery. Residents who eat in their room will be asked if food temperatures are satisfactory and will be given the option to eat in the dining room or have their meals reheated upon request. Dietary manager/designee will educate nursing staff on safely warming up meals in the microwave by 5/1/23. Dietary manager/designee will audit 10 residents' satisfaction with meal temps weekly x4 weeks then monthly x2 months.	

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 ______	03/17/2023

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
F 804	Continued From page 43	F 804	Dietary manager/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 842		5/1/23

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 ______	03/17/2023

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
F 842	Continued From page 44 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review (RR), the facility failed to accurately document medical equipment maintenance and cleaning records for one resident (Resident	F 842	The oxygen concentrator filter for (R16) was cleaned and documented in the medical record.	

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 ______	03/17/2023

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
F 842	Continued From page 45 (R)16) sampled. As a result of this deficent practice, the resident is at risk for the potential for exposure to dust and allergens that could adversely affect the resident. Findings include: (Cross-Reference to F908 Maintain all mechanical, electrical, and patient care equipment in safe operating condition) On 03/16/23 at 10:54 AM, conducted concurrent observation and interview with maintenance director (MAD). Observed cover and filter of Resident (R)16's oxygen (O2) concentrator (Serial#08BF020637) visibly soiled. Conducted a RR on 03/16/23 at 15:33 PM of R16's treatment record showed nursing staff documented cleaning oxygen tubing, concentrator bottle, and filter on 03/11/23. On 03/17/23 at 11:20 PM, RR of service records documented inspection and service of other facility O2 concentrators but no documented service for the O2 concentrator assigned to R16.	F 842	Residents using oxygen concentrators have the potential to be affected by this practice. An audit was completed to validate that tasks in the medical record relating to oxygen administration have been completed by the nurse. Oxygen orders were updated to have nursing document only those tasks that they are assigned to complete. Oxygen cleaning log was created to document that all oxygen concentrators were cleaned. Central supply/designee will conduct weekly cleaning of all oxygen concentrators and filters. Infection Preventionist/designee will conduct 5 random audits weekly x 4 weeks then monthly x 2 months on residents with oxygen orders to validate components of oxygen order that licensed nurse signs for have been completed. Infection Preventionist/designee will present findings at the facility's Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	
F 880 SS=F	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.	F 880		5/1/23

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 ______	03/17/2023

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
F 880	Continued From page 46	F 880		

Continued From page 46

§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 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

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 ______	03/17/2023

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
F 880	Continued From page 47	F 880		

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.

§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 observation, interview, 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.
As a result of this deficient practice, residents are at risk of exposure and contracting communicable disease(s) that has the potential to result in harm.

Findings include:

1) On 03/14/23 at 12:23 PM, observations were done of Certified Nurse Aide (CNA)26 as she passed lunch trays in Station 1. Observed CNA26 deliver three (3) trays to room 112 (which had all residents in the room marked as on TBP) with no hand hygiene or gloves worn/changed in between trays/residents. Then observed CNA26 deliver one (1) tray to room 113, and three (3)

Residents that were in rooms 112, 114, 210 during observation (3/14-3/16) were reviewed, no facility acquired infection were identified. Resident 42 has been discharged from the facility.
CNA26, CNA37 and PT6 were re-educated regarding hand hygiene, use of appropriate PPE and donning and doffing PPE on 4/14/23.

Current residents have the potential to be affected by this practice.
Residents with infections were reviewed for potential facility transmission of infection. Those in transmission-based precautions were reviewed to validate the need for precautions and that staff were following precautions.

Infection Preventionist/designee

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 ______	03/17/2023

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
F 880	Continued From page 48 trays to room 114. No hand hygiene or gloves were observed between trays/residents as CNA26 returned to the tray cart to grab and deliver each tray one by one. On 03/14/23 at 12:28 PM, an interview was done with CNA26 after delivering the seventh tray with no hand hygiene or gloves. CNA26 acknowledged that she should have conducted hand hygiene between meal trays/residents. On 03/17/23 at 11:27 AM, an interview was done with the facility Infection Preventionist (IP) in the facility Conference Room/OT Office. The IP confirmed that staff should be performing hand hygiene between residents, including when passing meal trays. 2) On 03/14/23 at 01:34 PM, observed Physical Therapist (PT)6 escort resident back to their room located in the section of Station 1 marked "Yellow Zone." PT6 was noted to be wearing an N95 respirator and what appeared to be a pair of eyeglasses. As PT6 exited the Yellow Zone room, a concurrent interview was done. PT6 stated that the pair of glasses she was wearing were for eye protection and did not have corrective lenses. When asked if the facility allowed her to wear the glasses as eye protection despite the lack of protective coverage anywhere but in front of her eyes, PT6 responded that it was only her first week at the facility and no one had said anything to her about it yet. PT6 confirmed that she was aware that she should be wearing adequate eye protection and an N95 respirator when in contact with any resident in the Yellow Zone. PT6 continued to work with residents in the Yellow Zone without donning adequate eye protection.	F 880	re-educated staff with potential patient contact on infection control and transmission-based precautions to include hand hygiene, hand hygiene during meal service, use of appropriate PPE and donning and doffing PPE. Infection Preventionist/designee re-educated nursing staff on adding transmission precaution signage to doors of residents on transmission-based precautions and removing when infection resolved. Infection Preventionist/designee re-educated staff who provide direct patient care on following transmission precaution signage. Facility to send out letter to contracted providers and vendors to follow transmission-based precautions in facility. A system for ongoing monitoring was developed and implemented. Infection Preventionist/designee will conduct PPE usage and hand hygiene observations for 10 staff weekly for 4 weeks, then monthly x 2 months to validate observation of standard precautions, transmission-based precautions and infection control techniques. Infection Preventionist/designee will conduct PPE usage and hand hygiene observations for 4 contracted providers/vendors weekly for 4 weeks, then monthly x 2 months to validate observation of standard precautions, transmission-based precautions and infection control techniques. Infection Preventionist/designee will present findings at the facility's Quality	

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 ______	03/17/2023

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
F 880	Continued From page 49	F 880		

On 03/16/23 at 11:27 AM, an interview was done with the IP in the facility Conference Room/OT Office. Per the IP, all staff working with residents in Station 1 should be aware that they are required to wear N95 respirators and face shields. The IP stated that the facility provides face shields to all staff so anyone who does not have one can get one at the entrance.

The IP reported that either she or the Director of Nursing (DON) conducts PPE audits daily to ensure staff are wearing the proper PPE and stated that she had not noticed what PT6 was using for eye protection. The IP then confirmed that for any eye protection to be considered adequate, it should have protection on the top and the sides, not just the front.

3) On 03/15/23 at 08:26 AM, observed Room 210 on droplet Transmission-Based Precautions (TBP) starting 03/14/23. Signs for droplet precautions were posted at doorway with red dot marking 210B. Observed Xray technician entering room without sanitizing hands, donning gown, or face shield to take chest Xray for Resident (R)37.

On 03/16/23 at 10:40 AM, conducted concurrent interview and Record Review (RR) with Infection Prevention (IP). She stated TBP signs are posted at the door of room and that Room 210 is currently on droplet precautions indicating necessity for staff entering to don an N95 mask, face shield, gown, and gloves prior to entering room. She also stated that the entire room and all residents are on droplet precautions and red dot on sign indicates the possible source of infection. She noted the status of R37 is pending testing results but that even if testing is negative, the

Provider's plan of correction (F 880):

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 ______	03/17/2023

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
F 880	Continued From page 50 room will remain on TBP until 3 days after any symptoms triggering TBP have cleared. IP confirmed that Xray tech should have donned all PPE prior to entry and doffed PPE when exiting room. 4) On 03/17/23 at 07:57 AM, observed Certified Nursing Assistant (CNA)37 donning gown and gloves prior to entering Room 210 without face shield to assist R37 eating. On 03/17/23 at 08:18 AM, conducted interview with CNA37 as she exited Room 210. She confirmed she should have donned a face shield prior to entering the room to assist residents. 5) On 03/14/23 at 08:51 AM, observed a sign outside of R42's door indicating R42 is under contact precautions and a PPE supply container below the sign with gowns and gloves. R42's curtain was drawn and observed Certified Nurse Aide (CNA) 16 come in and out of R42's drawn curtain not wearing a gown or gloves. CNA16 could be heard assisting R42 with care and was observed to exit R42's room with a trash bag of unidentified items not from the trash can. CNA16 did not hand sanitize her hands as she left R42's room. Concurrent observation of the sign outside of R42's room, inquired with CNA16 if R42 is under contact precautions, CNA16 stated the sign was supposed to be removed and was no longer under contact precautions. As CNA16 explained the reason R42 was under contact precautions a resident in another room could be heard yelling for help. CNA16 was observed to hold the trash bag filled with unidentified items and immediately assist the resident requesting for help, adjusting the resident to sit straight in her bed. CNA16 put the trash bag on top of the resident's bed and	F 880		

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 ______	03/17/2023

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
F 880	Continued From page 51	F 880		

touched the resident without hand sanitizing.

On 03/14/23 at 08:58 AM inquired with Registered Nurse (RN) 25 if R42 was currently on contact precautions, RN25 stated she did not know and that a paper is usually provided daily to indicate who is on TBP but did not receive it.

Review of R42's Electronic Health Record (EHR) documents in the nursing note on 03/16/23 "Discussed with ...[physician] ..., 3/2 blood cultures show no growth to date. Ok to remove from isolation."

On 03/17/23 at 10:09 AM an interview with Infection Preventionist (IP) was done. IP stated R42 was on contact precautions because he has extended spectrum beta-lactamese (ESBL) in urine, a contagious organism that causes infections. IP confirmed R42 was still on contact precautions on 03/14/23 and the contact precautions for R42 ended on 03/16/23. IP stated for donning in a contact precaution room, staff members providing care are to wear a mask, gloves, and a gown prior to entering the room. IP confirmed staff members should be hand sanitizing when exiting the room prior to providing care to another resident to prevent contamination.

6) On 03/15/23 at 08:21 AM observed Registered Nurse (RN) 20 and another nursing staff member enter R82's room without donning or doffing appropriate PPEs. At 08:24 AM, a sign was observed outside of R82's that all four residents, including R82, in the room are under droplet precautions.

Review of R82's Electronic Health Record (EHR) documents in the nursing note on 03/13/23 that

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 ______	03/17/2023

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
F 880	Continued From page 52	F 880		

R82 complained of body aches and nausea and vomited that day. R82 was tested for COVID-19 and influenza.

Review of the facility's list of residents in isolation dated 03/14/23, document R82 began droplet precautions on 03/13/23, pending PCR results.

On 03/17/23 at 10:09 AM an interview with Infection Preventionist (IP) was done. IP reported if one resident is on droplet precautions the facility considers the entire room on droplet precaution. IP stated R82 had a cough and was put on droplet precautions until the facility receives R82's COVID-19 and influenza test results. IP confirmed all staff members should be donning a mask, face shield, gown, and gloves prior to entering a droplet precaution room.

7) On 03/14/23 at 4:16 PM, observed R37 in bed holding napkins to his nose and appeared to have a bloody nose. On 03/15/23, observed transmission-based precaution signs posted documenting R37 was on droplet precautions the outside of R37's room. The signs documented PPEs that should be donned prior to going into the room is a face shield, mask, gown, and gloves. At approximately 12:15 PM, observed nursing staff assisting R37 and the staff's face shield was not properly pulled down and the staff's face was exposed. Staff saw this surveyor and proceeded to lower face shield and exited the room. Observed another nursing staff enter the room provide care for R37, exit the room without disinfecting his/her face shield. This staff disinfected his/her hands before entering the room directly across R37's then lifted up his/her face shield (touched the outside surface of the face shield) and proceeded to assist another

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 ______	03/17/2023

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
F 880	Continued From page 53 resident. On 03/16/23 at 10:40 AM, conducted an interview with the IP. Informed the IP of observations made of staff not properly wearing PPEs in R37's room and another staff not properly disinfecting their face shield after leaving the room. IP confirmed R37 is on droplet precautions and staff should don gloves, gown, mask, and a face shield prior to going into the room. IP confirmed that staff should have had their face shield down and initially stated that staff are not required to disinfect the outside for their face shield after exiting a room on droplet precaution. However, after reviewing the CDC recommendations and discussions with this surveyor the IP confirmed staff should disinfect their face shield after assisting a resident on droplet precautions.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review (RR), the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. This deficient practice has the potential to result in harm to residents on supplemental oxygen therapy. Findings include: (Cross-Reference to F842 Resident Records)	F 908	The oxygen concentrator filter for (R16) was cleaned on 3/17/23. Residents using oxygen concentrators have the potential to be affected by this practice. Facility oxygen concentrator filters were cleaned on 3/17/23. Facility oxygen concentrators were serviced by Stat Medical on 3/22/23. DON/designee will educate the Central Supply clerk to clean oxygen concentrator	5/1/23

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 ______	03/17/2023

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
F 908	Continued From page 54 On 03/14/23 at 02:51 PM, observed Resident (R)16's oxygen (O2) concentrator. Oxygen tubing and concentrator bottle were clean and labled 03/11/23 but outside cover of concentrator was visibly soiled with brown, sticky stain and gray dust on external filter casing. On subsequent observation on 03/15/23, oxygen concentrator was still not cleaned. On 03/16/23 at 10:54 AM, conducted concurrent observation and interview with maintenance director (MAD). MAD stated that an outside contractor is responsible for repair and maintenance of all O2 concentrators and stated that he would provide maintenance record for R16's O2 concentrator. On inspection with MAD, external cover had brown, sticky stain, filter casing and external filter were covered with gray, matted dust. MAD stated that filter should be cleaned by in-house maintenance personnel. On 03/16/23 at 15:33 PM, RR of R16's treatment record documented that nursing staff cleaned oxygen tubing, concentrator bottle, and filter on 03/11/23. On 03/17/23 at 11:09 AM, conducted concurrent observation and interview with Certified Nursing Assistant (CNA)16 and Registered Nurse (RN)27. CNA16 stated that CNAs do not change tubing, bottles, or filters. RN27 stated that nurses change tubing and concentrator bottle but do not clean filters. She stated that she believes maintenance cleans or changes the filters.	F 908	filters weekly. Central Supply/designee will conduct random audits on 3 residents with oxygen concentrators weekly x 4 weeks then monthly x2 months. Central supply/designee will present findings at the facility’s Quality Assurance and Performance Improvement meeting monthly until QAPI team recommends a lesser frequency.	