STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Department of Health, Office of Health Care Assurance (OHCA). The facility was found not to be in substantial compliance with 42 CFR 483 Subpart B. Survey Dates: 03/28/23 to 03/31/23 Survey Census: 91 Sample Size: 19	F 000		
F 623 SS=D	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.	F 623		4/21/23

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

Electronically Signed | 04/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 1	F 623		

(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;
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2 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 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 record review, staff interview, and review of policy, the facility failed to provide written notice of discharge for two residents (R), R92 and R73, out of four residents sampled. As a result of this deficiency, there was a potential for miscommunication and/or misunderstanding of the reason for resident's discharge.	F 623	F 623 Notice Requirements Before Transfer/Discharge 1. On 04/18/2023 the Director of Nursing completed a written notice of discharge to residents R92 and R73. This discharge notice was sent to the LTC Ombudsman. 2. On 04/20/23 the Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 3 Findings include: 1) Cross reference to F625. The facility did not provide written notice of bed-hold policy which was included in the transfer/discharge notification. Review of the electronic health record (EHR) indicated that R92 was admitted to the hospital on 03/03/23 for pancreatitis and discharged from the facility. Further review did not show any written notice of discharge to the resident and/or representative. During staff interview on 03/30/23 at 09:40 AM, Social Services Coordinator (SS1) acknowledged that the facility did not provide written notification of discharge to R92 and/or representative. During staff interview on 03/30/23 at 10:25 AM, Registered Nurse (RN)1 reviewed the "Facility Notification of Transfer or Discharge" form for R92 and said the family was verbally notified by phone of discharge but there was no written notification given. Review of facility policy titled "Discharge Notice Policy" revised on 03/01/18, read the following: "Purpose, [facility] will provide proper and timely notice to a resident who will be discharged as required by regulations and laws. The facility will work with the physician to obtain adequate documentation about the reason to discharge the resident. The facility will provide preparation and orientation to the resident, family and receiving facility prior to discharge ... B. Timing of the notice a. The transfer/discharge notice will be issued with a discharge date at least 30 days	F 623	Nursing/designee audited all other discharges to ensure that each received a notice of transfer/discharge form. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing/designee in serviced all of the nurses that a written notification of transfer/discharge must be given and signed by the residents/family member upon discharge/transfer. All new nursing staff hires will be in serviced on the requirement for giving a written notice to transferring/discharging residents. See policy and procedure on Discharge transfer notice. 4. The Director of Nursing/designee will audit each month that a written notice transfer/discharge is given to each resident who is discharged or transferred and will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4	F 623		

before the resident is transferred or discharged. i. The notice will be in a language and manner that the resident can understand. ii. If the transfer/discharge was an emergency, the notice will be issued as soon as practicable when: ... 4. An immediate transfer or discharge is required by the resident's urgent medical condition ... C. Contents of the notice Before the facility will transfer or discharge a resident, the facility will provide a written notice to the resident and resident representative in a manner and language in which is understood ..."

2) Cross Reference to F625. The facility did not provide written notice of bed-hold policy which was included in the transfer/discharge notification.

On 03/28/23 at 10:50 AM interviewed R73. R73 reported following admission to the facility he was hospitalized. R73 was unable to recall when, however, reported an ambulance came and took him to the hospital. R73 further reported he was not sure why he was being transferred to the hospital. Inquired if the facility provided written notice of transfer or bed-hold policy (ability to return to the facility). R73 responded that this information was not provided. R73 stated the acute hospital provided discharge locations and he chose to return to the facility.

Record review found R73's original admission date was 06/06/22. On 12/16/22, R73 was readmitted from the hospital. Further review found a document titled, "Facility Notification of Transfer or Discharge" with an admit date of 12/16/22. The form was not completed. Information regarding date of transfer/discharge;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 location; reason for transfer/discharge, signature of the responsible party being notified; and signature of charge nurse/facility representative were blank. The document included protection and advocacy contact phone numbers, bed hold policy, grievance procedure rights, and Medicaid insurance rights. A review of the census information documents the resident was readmitted to the facility on 12/16/22 from the hospital. On 03/31/23 at 08:30 AM interviewed SS1. Requested to review the notification to the State Long Term Care Ombudsman and written notification to the resident regarding the transfer. SS1 returned at 08:48 AM to report they have copy of notification to the Ombudsman. Requested SS1 to follow-up on written notification of transfer. On 03/31/23 at 1:45 PM, the Administrator provided a copy of the "Facility Notification of Transfer or Discharge" and explained when residents are sent to the hospital in an emergency, the facility does not provide the form to the resident. The facility will obtain the resident's signature upon their return to the facility. The Administrator confirmed written notification of transfer was not provided as soon as practicable or upon the resident's return to the facility.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §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	F 625		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 6 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 record review, staff interview, and review of policy, the facility failed to provide written notice of bed-hold policy for two residents (R), R92 and R73, out of four residents sampled. As a result of this deficiency, there was a potential for miscommunication and/or misunderstanding of the facility's bed-hold policy. Findings include: 1) Cross Reference to F623. R92 was transferred to a hospital. The facility did not provide R92 with a written notification of the	F 625	F 625 Notice of Bed Hold Policy/Before/Upon Transfer 1. On 04/18/2023 the Director of Nursing completed a written notice of PCH□s bed hold notice to residents R92 and R73. 2. On 04/20/023 the Director Nursing/designee audited all other discharges to ensure that each received a bed hold notice. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing/designee in serviced all of the nurses that a written notification of PCH□s bed hold notice must be given	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 7 transfer. Review of the electronic health record (EHR) indicated that R92 was transferred to the hospital on 03/03/23 for pancreatitis. 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 03/30/23 at 09:40 AM, Social Services Coordinator (SS1) acknowledged that the facility did not provide written notification of bed-hold policy to R92 and/or representative. During staff interview on 03/30/23 at 10:25 AM, Registered Nurse (RN)1 reviewed the "Facility Notification of Transfer or Discharge" form for R92 and said the family was verbally notified by phone but there was no written notification given. Review of facility policy titled "Bed Hold Prior to Transfer" with no date, read the following: "Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave ... Notice before Transfer 1. The facility will have a process in place to ensure residents and/or their representatives are made aware the facility's bed-hold and reserve bed payment policy well in advance of being transferred to the hospital or when taking therapeutic leave of absence from the facility. 2. The facility will have policies that address holding the resident's bed during periods of absence, such as during hospitalizations or therapeutic leave. 3. The facility will provide written information about these policies to residents and/or resident representatives prior to	F 625	and signed by the residents/family member upon discharge/transfer. All new nursing staff hires will be in serviced on the requirement for giving a written notice to transferring/discharging residents. See policy and procedure on Discharge transfer notice. 4. The Director of Nursing/designee will audit each month that a written bed hold notice is given to each resident who is discharged or transferred and will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 8 and upon transfer for such absences." 2) Cross Reference to F623. R73 was transferred to a hospital. The facility did not provide R73 with a written notification of the transfer. On 03/28/23 at 10:50 AM, R73 reported he was transferred to an acute hospital. Inquired whether the facility provided a written notification of the bed-hold policy. R73 responded that the facility did not provide bed-hold information. R73 clarified, the acute hospital provided choices of discharge locations and he chose to return to the facility. On 03/31/23 at 08:19 AM interviewed Registered Nurse (RN)1. Inquired whether R73 was provided with bed-hold information. RN1 reported the nurses will attempt to follow-up with residents' family or call the resident. RN1 reported bed-hold information is discussed at admission. RN1 deferred to social services. On 03/31/23 at 08:48 AM, SS1 reported the nursing department provides bed-hold information. A review of document titled; "Facility Notification of Transfer of Discharge" includes the facility's bed-hold policy. On 03/31/23 at 01:45 PM, Administrator confirmed, R73 was not provided written notice of the transfer which would include information on the facility's bed-hold policy.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility did not assure assessments accurately reflected the residents' status for two (Residents 19 and 91) out of eighteen assessments reviewed. The facility inaccurately coded Resident (R)19 with a facility-acquired Stage III pressure ulcer and R91 as being discharged to the hospital, instead of to the community. This deficient practice has the potential to affect the development of a person-centered care plan, resulting in not meeting the needs of the residents. Findings include: 1) On 03/28/23, the facility provided a copy of the "Resident Matrix" (identifies pertinent care categories for: newly admitted residents in the last 30 days who are still residing in the facility, and all other residents). Resident (R)19 was identified with a Stage III pressure ulcer which was facility acquired. R19 was admitted to the facility on 02/01/23. Diagnoses include displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing; unspecified fall; and dementia, unspecified severity, without behavioral disturbance. A review of the admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 02/07/23 noted in Section M. Skin Conditions, R19 was not coded with an unhealed pressure ulcer. R19 also noted with a surgical wound and skin tear. Subsequent MDS for a significant change with an ARD of 03/06/23 documented one	F 641	F 641 Accuracy of Assessments 1 □ MDS and IDT 1. On 04/05/2023 the Director of Nursing corrected R91□s Minimum Data Set (MDS) to discharge home and not to the hospital. On 04/05/2023 the Director of Nursing corrected R19□s MDS to wound present at admission and not acquired in the facility. Both MDS Coordinators were educated on the corrections. 2. On 04/14/2023 the Director of Nursing audited all the MDSs to ensure the accuracy of all the MDS assessments. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing in serviced the MDS Coordinators on the errors and the need for accurate assessments. All new MDS Coordinators and the Interdisciplinary Team were in serviced on 04/05/2023 and the need to be accurate with the assessments. All new Interdisciplinary Team staff hires will be in serviced on the requirement for accurate assessments. Refer to Chapter 1 of the MDS 3.0 RAI User□s Manual. 4. The Director of Nursing/designee will audit each month that the MDS Assessments are accurate will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10	F 641		

unhealed Stage III pressure ulcer that was not present upon admission/reentry to the facility. The facility developed a care plan for the healing of the pressure ulcer.

R19's acute hospital discharge summary (discharge date of 02/01/23) noted the resident presented at the hospital due to an unwitnessed fall at home resulting in a left intertrochanteric femur fracture. R19 was admitted for operative fixation.

Further review found the wound consultant's report. The report of 02/23/23 noted R19 had a wound located on the left lateral leg. The "wound occurred by pressure mechanism after being found on the ground prior to admission". The consultant assessed the wound and made treatment recommendations. The impression was a pressure ulcer of left leg, stage III.

On 03/30/23 at 2:46 PM a telephone interview was conducted with the Director of Nursing (DON). The DON reported R19 was admitted with the wound. The facility's wound consultant assessed, and indicated it was a Stage III pressure ulcer. Based on the consultant's report, the MDS coordinator coded it as a new wound acquired in the facility. The DON reported the assessment was inaccurate as the wound was present on admission. The DON stated corrections will be made.

2) R91's electronic health record (EHR) was reviewed. Read R91's discharge "Minimum Data Set (MDS)" assessment with "Assessment Reference Date (ARD)" of 02/09/23. It revealed that R91 was admitted to the facility on 01/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 from the hospital for encephalopathy (damage or disease that affects the brain). R91 received speech, language, and pathology (SLP), occupational therapy (OT), and physical therapy (PT) services. The discharge MDS further revealed that R91 was discharged to "03. Acute hospital." Under "Progress Notes," read "Social Services Note" documented on 02/01/23 at "14:12 (2:12)" PM. It stated, "... confirmed a pickup time for resident of 2PM on 2/9/23 and indicated he [son] would be brining [sic] resident to her home and staying with her and providing care for now..." On 03/30/23 at 2:50 PM, a phone interview with the Director of Nursing (DON) was conducted. The DON concurrently reviewed R91's discharge MDS in the EHR. DON confirmed that R91 was coded as being discharged to the hospital. After reviewing R91's discharge progress notes, DON stated that R91's discharge MDS was coded in error as she was discharged home and not to the hospital. DON stated that they were auditing three MDS assessments a month up until November 2022 and stopped. DON further stated that they will resume auditing MDS assessments once a month starting in April.	F 641		
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	F 656		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 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 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, record review and	F 656	F 656 Develop/Implement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 interviews, the facility failed to develop person-centered care plans for 3 residents (R) (R35, R52, and R86) of 18 residents which addressed: 1) the risks for bruising and bleeding with the use of anticoagulants; 2) non-pharmacological interventions were developed for a resident on sleep medication for insomnia; 3) non-pharmacological interventions were not developed for a resident receiving routine and prn (as needed) pain medication and 4) education for the care of a urinary catheter tubing and bag system. This deficient practice has the potential to result in not meeting residents' needs and affect residents' ability to meet their highest physical, mental, and psychosocial needs. Findings include: 1) R35 was admitted to the facility on 03/12/21. R35 has a physician's order for routine administration of Eliquis (an oral anticoagulant that is used to prevent and treat certain types of blood clots), 5 mg (miligrams), two times a day and aspirin tablet, 81 mg, one time a day for blood clots and atrial fibrillation. A review of the annual Minimum Data Set (MDS) with assessment reference date (ARD) of 12/08/22 documents in Section N. Medications, R35 received an anticoagulant seven days in the last seven days. The resident's care plan did not identify the use of an anticoagulant with interventions to monitor for adverse effects (bleeding, bruising, nose bleeds or bleeding of gums) and providing care to address resident at risk for bruising and bleeding. On 03/31/23 at 08:07 AM an interview and	F 656	Comprehensive Care Plan 1. On 04/09/2023 the Director of Nursing individualized and updated the care plan for: R86 on education for caring for her urinary catheter with tubing and bag system, including the proper catheter insertion/exit site care such as clean catheter daily with mild soap and water, wipe away from urinary opening, notify physician when there are signs and symptoms of a urinary tract infection such as fever, abdominal pain, less or no urine in bag, blood/clots in the bag. R35 on use of an anticoagulant Eliquis with interventions to monitor for adverse effects (bleeding, bruising, nose bleeds or bleeding gums) and providing care to address resident at risk for bruising and bleeding such as with shaving, prevention of injury. R35□s on non-pharmacological interventions to address pain such as such as repositioning of body and limbs, provide distraction, activities, ice pack as indicated. R52□s on non-pharmacological interventions to address insomnia such as provide calm, quiet environment □ closing door, turning off light. toileting, incontinent care, offering snacks, redirect, playing music. 2. On 04/10/2023the Director of Nursing/designee audited all care plans to ensure that each is individualized (anticoagulant use) and includes non-pharmacological interventions for pain and insomnia. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing in serviced the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 concurrent record review was done with Registered Nurse (RN)1 at the nurse's station. RN1 confirmed the interdisciplinary team did not include the use of an anticoagulant in the resident's plan of care. RN1 reported the licensed nurses are monitoring R35 for bleeding and bruising in the Treatment Administration Record (TAR). RN1 checked the Kardex (resident care instructions for certified nurse aides) to inform certified nurse aides R35 is at risk for bruising and bleeding due to the use of an anticoagulant. RN1 confirmed the Kardex did not provide care instructions for the certified nurse aides. RN1 was asked whether the interdisciplinary team develops a plan of care to address the use of an anticoagulant. RN1 responded "yes". On 03/31/23 at 12:41 PM an interview was conducted with Certified Nurse Aide (CNA)8. CNA8 was asked if there are special instructions for providing care to R35. CNA8 responded R35 will get upset if you use too much pressure during peri care. Inquired if CNAs observe for bruises or bleeding during care (i.e., shower) to the nurse. CNA8 again responded R35 gets upset when you use pressure during peri care and at times will refuse to change personal brief. On 03/31/23 at 3:30 PM, the Minimum Data Set Coordinator (MDSC) was asked whether the interdisciplinary develops a care plan for residents receiving an anticoagulant. MDSC responded the team will usually create care plan for use of anticoagulant. 2) Cross Reference to F757. R35 receives routine and prn medications for pain related to brachial plexus disorder. The interdisciplinary	F 656	Interdisciplinary Team on the requirement for individualized care plans including non-pharmacological interventions. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. Refer to policy and procedure, Baseline, Comprehensive and Discharge Care Plan. 4. The Director of Nursing/designee will audit each month that care plans are individualized (anticoagulant) and include non-pharmacological interventions (pain, insomnia) and will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15	F 656		

team did not develop non-pharmacological interventions to address R35's pain.

The facility provided a policy and procedure for care plans (last revision date of 08/25/21). The purpose of the policy is "so that each resident will have a person-centered comprehensive care plan developed and implemented to meet his or hers preferences, goals, and address the resident's medical, physical, mental, and psychosocial needs. The procedure includes the interdisciplinary team will complete assessments/evaluations to obtain information pertinent to the development of the comprehensive care plan, identifying resident-specific problems, goals, and interventions. The comprehensive care plan will identify resident's needs, choices, and preferences.

3) R52 was admitted to the facility on 02/03/22. Diagnoses include but not limited to Alzheimer's disease, unspecified; vascular dementia, unspecified severity with mood disturbance; adjustment disorder with mixed disturbance of emotions and conduct; constipation; and insomnia.

Review of the physician order for March 2023 include Trazodone HCl tablet (antidepressant and sedative), 175 mg by mouth at bedtime for insomnia and Melatonin tablet, give 8 mg by mouth at bedtime for insomnia (family supplies). Review of R52's annual MDS with an ARD of 02/10/23 documents in Section N. Medications, R52 received an antidepressant seven days of the last seven days. A review of the care plan found no non-pharmacological interventions for insomnia. For example, sleep hygiene

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16	F 656		

interventions (behavioral and environmental practice to help with insomnia).

On 03/30/23 at 09:44 AM an interview and concurrent record review was conducted with Registered Nurse (RN)1 at the nurse's station. Reviewed R52's care plan for the use of Trazodone to treat insomnia. RN1 found a plan for the use of an antidepressant medication related to insomnia. The goal was for R52 to be free from discomfort or adverse reactions related to antidepressant therapy through the next review date.

The interventions included:
1) Administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness every shift; and
2) Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance problems, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; insomnia; and appetite loss, weight loss, nausea/vomiting, dry mouth, and dry eyes.

RN1 was asked if nursing documents R52's number of hours of sleep at night or whether a goal for how many hours of sleep R52 needs. RN1 reviewed the Medication Administration Record (MAR) and reported licensed nurses document interventions implemented and monitor behavior related to the use of Trazodone. Nurses are documenting every shift in the MAR for no behaviors, unable to sleep, and restlessness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17	F 656		

RN1 confirmed non-pharmacological interventions to address R52's insomnia were not developed.

4) On 03/25/23 at 12:23 PM, R86 was observed to have a urinary catheter with a tubing and bag system.

On 03/29/23 at 09:21 AM, R86 was interviewed in her room. R86 had a urinary catheter tubing and bag system because of her diagnosis of retention of urine and hoped to have it taken out before she was discharged home soon.

On 03/31/23 at 08:25 AM, R86 and Registered Nurse (RN)3 were interviewed in R86's room. R86 stated that the staff provided her education about caring for her urinary catheter with tubing and bag system. R86 was taught to clean the catheter insertion/exit site with a wet, soapy cloth and to keep catheter tubing and bag system clean. RN3 confirmed that education for care of her urinary catheter with tubing and bag system was provided to R86 and that R86 mostly does her own catheter insertion/exit site care, but at times may need assistance.

Reviewed R86's electronic health record (EHR). "Admission Record" revealed that R86 was a 75 year old resident admitted on 02/27/23. Care plan for R86's "...Indwelling catheter (urinary catheter with a tubing and bag system)..." revealed that it was placed on 02/28/23. Care plan did not include any personalized interventions to identify that she was able to receive and was provided education for caring for her urinary catheter with tubing and bag system, the need for follow up after education was given to her, and that R86

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 may need assistance at times with proper catheter insertion/exit site care. On 03/31/23 at 12:22 PM, a phone interview was conducted with the Director of Nursing (DON). The DON confirmed that R86's care plan should be personalized according to her needs and capabilities. Reviewed the policy, "CARE PLANS - BASELINE, COMPREHENSIVE, AND DISCHARGE," last revised on 08/25/21. It stated, "PURPOSE: Comprehensive Care Plan The purpose of the Comprehensive Care Plan policy is so that each resident will have a person-centered comprehensive care plan developed and implemented to meet his or hers other preferences, goals, and address the resident's medical, physical, mental, and psychosocial needs."	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to follow bowel regimen protocol in accordance with the physician orders for one of one resident (R), R52,	F 684	F 684 Quality of Care 1. On 04/17/2023 RNs were educated on the need to administer the suppository/enema as ordered on	4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 19 sampled with constipation. The facility also failed to have a lab drawn and follow up on the results for R42's blood sugar management. These deficient practices have the potential to result in adverse consequences in residents needing bowel or blood sugar management. Findings include: 1) On the morning of 03/28/23, R52 was observed lying in bed. The resident was grimacing. R52 was asked if he had pain. The resident responded he had stomach problems. R52 was asked whether medication was provided to facilitate bowel movement. R52 confirmed medication was successful, however, had a sandwich last night and not feeling well. A follow-up visit with R52 at 2:36 PM, R52 still expressed presence of a sore stomach and tried to eat some lunch. Record review noted R52 was admitted to the facility on 02/03/22. Diagnoses include constipation, unspecified; Alzheimer's disease, unspecified; vascular dementia, unspecified severity, with mood disturbance; and insomnia, unspecified. The physician orders included, MiraLax Powder 17 gm (grams)/scoop by mouth one time a day for constipation; MiraLax Powder 17 gm/scoop by mouth as needed for constipation; Lactulose Solution, 10 gm/15 ml, give 30 ml by mouth as needed for no BM (bowel movement) for two days; Bisac-Evac Suppository, 10 mg, insert one suppository rectally as needed for no BM for three days; and Enema Ready-To-Use, insert one dose rectally as needed for diagnosis of no BM x3 days and suppository not effective.	F 684	03/20/2023, the third day of no bowel movement and was administered on the 4th day. On 04/18/2023 LPN was educated as no Lactulose was administered for no BM on the second day (03/24/2023). For R42 the physician orders for A1C on 06/07/2023 was found to have been entered as a Laboratory Category when it should have also been entered as PM shift to fax lab requisition to DLS by 10 pm NOC to review and confirm as a result no laboratory slip was generated. RNs were educated on the correction and the correct procedure for entering A1C lab orders. On 03/20/2023 physician noted that an A1C was not necessary as R2 was hospice. 2. On 04/19/2023 the Director of Nursing/designee audited all other medication administration records (MAR) to ensure that residents were given the correct medications for certain days of no BM. The physician orders (lab) were audited to ensure that each was completed and accurate. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing/designee in serviced the nursing staff to ensure that medications were administered as ordered and that physician orders were entered accurately. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. Refer to policy and procedure, Quality of Care. 4. The Director of Nursing/designee will audit each month that medications are administered as ordered and physician orders are entered correctly and will report	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 A review of the annual Minimum Data Set with an assessment reference date of 02/10/23 documents R52 was always incontinent of bowel and bladder. R52 also coded to require extensive assist with one-person physical assist for toilet use. R52 has a care plan for bowel incontinence and risk of constipation (date initiated 02/03/22 and revised on 02/14/22). The goal is for R52 to have normal BM at least every 2-3 days. Interventions include administer bowel regimen as ordered; check resident every two hours and assist with incontinent care as needed; and provide loose fitting, easy to remove clothing. Also noted, R52 receives an antidepressant (Trazodone for insomnia) with a side effect of constipation. On 03/30/23 at 09:44 AM an interview and concurrent record review was done with Registered Nurse (RN)1 at the nurses' station. RN1 reviewed the physician orders for the bowel protocol, confirmed orders: Lactulose if no BM for two days, suppository for no BM for three days, and enema for no BM for three days and suppository ineffective. RN1 assisted with the review of the Medication Administration Record (MAR) and documentation of R52's BM history. RN1 noted R52's last bowel movement was on 03/17/23. There was no bowel movement from 03/18/23 through 03/21/23 (four days). Lactulose was administered on 03/19/23 at 05:56 PM (second day). The medication was documented as ineffective. On 03/21/23 at 10:15 PM a suppository was provided. Suppository was noted to be ineffective. R52 had two bowel movements on 03/22/23. After the review, RN1 confirmed R52's bowel protocol was not followed,	F 684	the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21	F 684		

the suppository was administered on the fourth day, it should have been administered on 03/20/23 (third day of no bowel movement).

Further review noted R52's last bowel movement was on 03/22/23. There was no bowel movement for two days (03/23/23 and 03/24/23). There was no documentation Lactulose was provided on the second day of no bowel movement. The MAR documented a suppository was administered on 03/25/23 at 11:02 PM (third day of no bowel movement). This administration was documented as ineffective, and a suppository was administered on 03/26/23 at 07:35 AM with effective results. RN1 reported Lactulose should have been administered on 03/24/23, the second day of no BM.

2) Cross Reference to F756 - Drug Regimen Review, Report Irregular, Act On - facility failed to draw laboratory tests recommended by consultant pharmacist.

Review of electronic health record (EHR) for R2 was done. Medication Regimen Review (MRR) dated 05/31/22 revealed that the consultant pharmacist recommended the laboratory testing for A1C (average blood sugar level the past 3 months) and BMP (Basic Metabolic panel - test to check fluid balance and level of electrolytes) be considered. Review of laboratory results in the EHR done and was unable to find A1C and BMP results for June and July 2022.

Concurrent record review and interview with the Administrator done on 03/31/23 at 11:05 AM in her office. Reviewed MRR dated 05/31/22 scanned into EHR. Asked if A1C and BMP were checked as recommended by the consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22 pharmacist, she said she will "look into it." Further review of the EHR under "Results" revealed that there was a completed lab order on 06/07/22 for A1C and BMP. At 3:00 PM, phone interview with Administrative Assistant (AA) confirmed that the facility's contracted laboratory services provider did not receive any specimen from R42 for A1C and BMP testing and there was no documentation that the attending physician agreed or disagreed with the consulting pharmacist's recommendation. Concurrent interview and record review conducted with Registered Nurse (RN)2 on 03/31/23 at 3:55 PM in the conference room. Asked RN2 why the A1C and BMP testing ordered on 06/07/22 was noted as completed in the EHR but the contracted laboratory services provider said they did not receive any specimen. RN2 replied that "the order was inputted into the EHR incorrectly and because of this, it did not show in the MAR (Medication Administration Record). If it does not show in the MAR, the secretary would not create a requisition for the lab (laboratory test)."	F 684		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the	F 756		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 23 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to draw laboratory tests for one resident (R), R2, as recommended by the consultant pharmacist. This deficient practice has the potential to cause adverse consequences for residents where the consultant pharmacist has recommended actions to be taken for medication management. Finding includes:	F 756	F 756 Drug Regimen Review, Report Irregular, Act On 1. For R42 the physician orders for A1C on 06/07/2023 was found to have been entered as a Laboratory Category when it should have also been entered as PM shift to fax lab requisition to DLS by 10 pm NOC to review and confirm as a result no laboratory slip was generated. RNs were educated on the error and the correct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 24 Cross reference to F684 Quality of Care - laboratory order was not properly entered in the electronic health record (EHR) and there was no laboratory requisition generated. Reviewed electronic health record (EHR) for R2. R2 was admitted on 03/21/22 for hospice care. Diagnoses include but not limited to diabetes (high level of sugar in the blood), long term use of insulin, chronic kidney disease, and congestive heart failure (condition where the heart does not pump blood efficiently causing fluid buildup in the feet, arms and lungs). Ordered medications include insulin (regulates blood sugar levels) and furosemide (water pill). Review of a Medication Regimen Review (MRR) dated 05/31/22 revealed that the consultant pharmacist recommended the laboratory testing for A1C (average blood sugar level the past 3 months) and BMP (Basic Metabolic panel - test to check fluid balance and level of electrolytes) be considered. Review of laboratory results in the EHR was done and unable to find A1C and BMP results for June and July 2022. On 03/31/23 at 09:40 AM, asked Administrator for a copy of the A1C and BMP results that were drawn for the R42 as recommended by the pharmacist. At 10:50 AM, Administrative Assistant (AA) provided a copy of the Nurse Practitioner's visit note dated 02/06/23. Documented in the note were BMP results from 10/24/22 and A1C results from 03/14/22. Concurrent record review and interview with the Administrator done on 03/31/23 at 11:05 AM in her office. Asked what the facility's process was	F 756	procedure for entering A1C lab orders. On 03/20/2023 physician noted that an A1C was not necessary as R2 was hospice. On 03/20/2023 the Medication Regimen Review (MRR) was printed for March 2023 and the physician noted that since the resident was hospice an A1C was not required. 2. On 04/19/2023 the Director of Nursing/designee audited all the medical records for accuracy of entered physician orders and all Medication Regimen Review were file for each resident for each month. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing/designee in serviced the nursing staff on the proper procedure for entering physician orders (lab). The nursing and clinical clerks audited the records to ensure that all of MRRs were accounted for, followed up on and filed within the medical records within 30 days. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. Refer to policy and procedure, Laboratory Services and Medication Regimen Review and Reporting. 4. The Director of Nursing/designee will audit each month that physician orders are entered correctly, all MRRs are accounted for, followed up and filed within the medical records within 30 days and will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 25 for reviewing the monthly MRRs. Administrator replied that the consultant pharmacist sends the MRRs to the Director of Nursing (DON). The DON then distributed the MRRs to the nurses' stations and the nurse assigned to that unit reviews them. For any MRRs that had recommendations from the pharmacist, the MRR is placed in the physician's inbox at the nurses' station. When the attending physicians make rounds, they note on the MRR if they agree or disagree with the recommendations and return them to the nurses for review. Any physician's orders are then inputted into the EHR. The MRRs are then scanned into the EHR by the unit secretaries. Administrator then showed the MRR for R42 dated 05/31/22 that was in a binder in her office. Asked if A1C and BMP were checked as recommended by the consultant pharmacist, she said she will "look into it." At 03:00 PM, phone interview with AA confirmed that the facility's contracted laboratory services provider did not receive any specimen from R42 for A1C and BMP testing and there was no documentation that the attending physician agreed or disagreed with the consulting pharmacist's recommendation. Reviewed facility's policy "Medication Regimen Review and Reporting" with an effective date of September 2018. Page two stated, "8. . . . Recommendations shall be acted upon within 30 calendar days. . . . the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record."	F 756	committee.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		4/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 26 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff members, the facility failed to assure pain medication was provided with adequate indication for its use for one resident (R), R35, of five residents sampled for medication review. The prn (as needed) medications for pain did not indicate the parameters for its use or include non-pharmacological interventions to relieve pain. This deficient practice has the potential to ensure the resident attains the highest practicable mental, physical, and psychosocial well-being. Findings include:	F 757	F 757 Drug Regimen is Free from Unnecessary Drugs 1. On 04/17/2023 the Director of Nursing added the parameters for pain medication Morphine Moderate Pain (4 □ 6), and Severe Pain (7 □ 10). Tylenol Mild Pain (1 □ 3) and non-pharmacological interventions on the care plan to relieve pain such as Repositioning of Right Arm, Distraction such as talking about Surfing or Sci-Fi Movies, and relaxation technique, deep breathing for R35. On 04/23/2023 the PharD reviewed and followed up on R35□s pain regimen.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 27 R35 was admitted to the facility on 03/12/21. Diagnoses include but not limited to brachial plexus disorder (injury caused by damage to those nerves, typically from trauma, tumors, inflammation, pressure, athletic injuries, or being stretched too far); chronic systolic (congestive) heart failure; ischemic cardiomyopathy; basal cell carcinoma of skin or other parts of face; constipation; Type 2 diabetes mellitus with other skin complications; and venous insufficiency. On 03/29/23 at 08:06 AM an interview was conducted with R35. R35 reported having pain in the right arm which is managed by medication. A review of the physician's order for management of pain includes the following routine and prn (as needed) medications: 1) gabapentin capsule, 300 mg (miligram), give by mouth two times a day for pain; 2) methadone HCl, 10 mg, give three tablets by mouth every 8 hours for chronic right arm pain; 3) monitor for pain every shift; 4) acetaminophen tablet, 325 mg, give two tablets by mouth every four hours as needed for pain; and 5) morphine sulfate tablet, 30 mg, give 180 mg by mouth every 4 hours as needed for pain-severe. A review of the Medication Administration Record (MAR) for March 2023 documents no prn of acetaminophen was administered. R35 was received prn of morphine sulfate on 18 of 31 days with two administrations of prn medications on 03/15/23 and 03/20/23. The pain level ranged from 5 to 10. The pharmacy medication review from September 2022 to March 2023 does not address R35's pharmacological pain regimen.	F 757	2. On 04/18/2023 the Director of Nursing/designee audited the MARs to ensure that each PRN pain medication had parameters for administration. Audited the resident care plans to include such as repositioning of body and limbs, provide distraction / activities, ice pack / warm compress as indicated as non-pharmacological interventions for pain. On 04/23/2023 the PharD audited other resident□s pain regimen to ensure a complete review and recommendation. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing/designee in serviced the nursing staff on ensuring that each PRN pain medication had parameters for administration and that care plans included non-pharmacological interventions for pain. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. Refer to policy and procedure, Medication Management. 4. The Director of Nursing/designee will audit each month that PRN pain medications have parameters for administration and care plans have non-pharmacological interventions for pain and will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 28	F 757		

Review of the annual Minimum Data Set (MDS) with an assessment reference date of 12/08/22 notes R35 was on a scheduled pain medication regimen, prn pain medications, and no non-medication intervention for pain in the last five days. R35 reported having pain constantly which affected ability to sleep at night and limited day-to-day activities. R35 numerically rated pain as 10 (highest on the pain scale).

A care plan was developed to address R35's pain related to brachial plexus disorders. Interventions included:
1) The resident's pain is aggravated by movement.
2) The resident's pain is alleviated/relieved by PRN morphine and scheduled methadone.
3) Anticipate the resident's need for pain relief and respond immediately to any complaint of pain.
4) Evaluate the effectiveness of pain interventions.
5) Identify and record previous pain history and management of that pain and impact on function to identify previous response to analgesia including pain relief, side effects and impact on function.
6) Monitor/document for side effects of pain medication (constipation, new onset or increased agitation, restlessness, confusion, hallucinations, dysphoria, nausea, vomiting, dizziness, and falls).
7) Monitor/record pain characteristics every shift (severity scale, anatomical location, onset, duration, aggravating factors, and relieving factors).
8) Monitor/record/report to Nurse resident complaints of pain or requests for pain treatments; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 29 9) The resident is able to call for assistance when in pain, reposition self, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain. On 03/31/23 at 08:07 AM an interview and concurrent record review was conducted with Registered Nurse (RN)1 at the nurses' station. RN1 confirmed the orders to manage R35's pain. Inquired what are the parameters for administering morphine. RN1 reviewed the MAR and responded morphine was administered for numeric pain levels between 5 and 10, mostly 9. Further inquired when acetaminophen is administered. RN1 confirmed the physician orders does not differentiate the use of morphine and acetaminophen. RN1 noted orders indicate morphine to be provided for severe pain (no numeric value) and the order does not include numeric pain levels for administration of acetaminophen. RN1 reviewed R35's care plan for pain and confirmed the interdisciplinary team did not develop non-pharmacological interventions to alleviate the resident's pain.	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility did not ensure that medication error rate was below five percent (%). Two administration errors to resident (R)243 out of a sample of 5	F 759	F 759 Free of Medication Error Rts 5 Prcnt or More 1. On 04/19/2023 the Director of Nursing educated/observed RN8 on the proper	4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 30 residents, were observed out of 32 opportunities, resulting in a 6.25% medication error rate. This deficient practice has the potential for inadequate administration of medications and/or adverse effects to residents. Finding includes: On 03/30/23 at 08:42 AM, observed Registered Nurse (RN) 8 perform medication administration at the Lehua section of the facility. Observed RN8 administer fluticasone propionate nose spray and Trelegy inhaler to resident (R) 243. RN8 notified R243 that she will be giving her nose spay and inhaler. RN8 was holding the base of the nasal applicator between her index and middle fingers with her thumb on the bottom of the bottle. RN8 inserted the nasal applicator into R243's left nostril and pressed the bottom of the bottle twice. RN8 then inserted the applicator in the left nostril, administered 2 sprays then replaced the cover for the applicator. RN8 then got a cup of water and told the R243 to use it to rinse her mouth after administration on the inhaler. RN8 told R243 to take a deep breath, but the inhaler was not yet on R243's lips. R243 took a deep breath through her nose. RN8 then told R243 to breath normally through her mouth as she placed the inhaler on R243's lips. R243 took a short and quick beath through her mouth with her lips around the mouthpiece of the inhaler. RN8 then asked R243 to rinse her mouth and use the cup to spit out the water. RN8 then went back to the medication cart to document the medications administered in the computer. At 1:30 PM, conducted an interview with RN8 at the seating area outside of a resident's room. Asked RN8 to talk us though how to administer a	F 759	procedure of administrating Fluticasone Propionate nose spray and Trelegy inhaler. 2. On 04/21/2023 the Director of Nursing/designee educated/observed the RN staff on the proper procedure on administrating Fluticasone Propionate nose spray and Trelegy inhaler. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing in serviced all RN staff on the proper procedure of administrating Fluticasone Propionate nose spray and Trelegy inhaler. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. Refer to manufacture inserts and policy and procedure, Oral Inhalations and Nasal Administration. 4. The Director of Nursing/designee will observe each month that the proper procedure of administrating Fluticasone Propionate nose spray and Trelegy inhaler is being followed and will report the audit findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 31	F 759		

nasal spray and an inhaler. RN8 replied: "I would read the directions given by the doctor on the label of the medication, if it has to be given to both nostrils, let the resident know what is about to be done, uncap the nasal spray and spray into nostril, give resident time to breath it in then do the same for the other nostril." When asked if she should cover the other nostril while giving the nasal spray, RN8 said: "the directions do not say to cover the other nostril." Asked what the resident needs to do before being given the nasal spray, RN8 said "if the nose is dirty, clean it. Her breathing was okay, so I went ahead and administered the spray." When asked about the administration of the inhaler, RN8 said, "read the directions, uncap the inhaler, have a cup of water ready to rinse the mouth, have the resident take a deep breath when the inhaler is on the lips then exhale." Asked RN8 if medication administration was part of the orientation program when she was in training. She replied that part of the orientation was on medication administration, and there was a checklist they had to complete. Asked RN8 if we could review the package insert for the nasal spray and inhaler, she said she will get them from the medication cart. Package insert for the nasal spray stated: "Step 1. Blow your nose to clear your nostril. Step 2. Close one nostril. Tilt head forward slightly. . . insert the nasal applicator into the other nostril. . . Step 3. Start to breath in through your nose and WHILE BREATHING IN press firmly and quickly down on the applicator. . . Step 4. Breath out through your mouth. Package insert for the inhaler stated: ". . . Step 2. . . While holding inhaler away from your mouth, breath out (exhale) fully. . . Step 3. Inhale your medicine. . . Put mouthpiece between your lips. . . Take one long, steady, deep breath in through your mouth. . . hold your breath for about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 32 3 to 4 seconds. . . Step 4. Breathe out slowly and gently. . ." Asked RN8 what would she have done differently after reading the package inserts for the nasal spray and inhaler. RN8 responded that for the nasal spray, she would have asked R243 to blow her nose first, closed one nostril, tilted her head forward, told resident to inhale through nose then exhale through her mouth, and clean the tip of the applicator after use. For the inhaler, RN8 said she would make sure the resident exhaled first, instructed her to take a long and deep breath through her mouth when her mouth was sealed around inhaler mouthpiece, kept fingers off the vent and told the resident to hold her breath after. When asked what the concern would be if the package insert instructions were not followed when administering nasal sprays and inhalers, RN8 responded the residents would not get the full dose the medication, and they would not be effective. RN8 also stated that: "I'll need to start reading the package inserts of meds (medications)."	F 759		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 33 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews with staff, and record review, the facility failed to assure a system was established to ensure the dish machine sanitization process was in proper working order and failed to ensure labeling of food items. This deficient practice has the potential to result in foodborne illnesses. Findings include: 1) On 03/29/23 at 10:45 AM observed the Cook washing dishes. Inquired whether dishes are sanitized by heat or chemicals. The cook responded that the dish machine is supposed to sanitize dishes by heat, however, for a prolonged period, the water temperature did not reach 180 degrees Fahrenheit. The cook reported there is a problem with the heater, so it does not reach the appropriate temperature. Further queried what is being done to sanitize the dishes. The cook explained that initially the dish machine will start okay but over a period, the machine does not meet the temperature. The cook responded that the dishes were immersed in quaternary solution to ensure sanitization. Cook ran the dish machine, observed the water temperature of the wash cycle was 160 degrees Fahrenheit and the rinse cycle was 150 degrees Fahrenheit. On 03/29/23 at 11:20 AM the Food Service Manager (FSM) was interviewed. FSM clarified	F 812	F 812 Food Procurement, Store/Prepare/Serve-Sanitary 1. On 04/13/2023 the Assistant Administrator and the Food and Nutritional Services Manager (FSM) reviewed and implemented a Chlorine Sanitizer Test Procedure for Low-Temperature for the dish machine; labeled with date all food items including individual food items; and discarded all unlabeled and expired food times. And on 04/12/2023, the Food Service Manager defrosted and cleaned the ice machine. 2. On 04/16/2023, the FSM implemented a policy and procedure for the Chlorine Sanitizer Test Procedure for Low-Temperature for the dish machine (dishwasher); labeling with date all food items including individual food items (cooks); and discarding all unlabeled and expired food times (cooks). And monthly defrosting and cleaning of the ice machine. 3. On 04/19/2023 and 04/20/2023 the FSM/Assistant Administrator in serviced the entire kitchen staff and audited daily for compliance with the Chlorine Sanitizer Test Procedure for Low-Temperature for the dish machine; labeled with date all food items including individual food items; discarded all unlabeled and expired food	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 34 the dish machine did not meet the required temperature so was converted to a low temperature dishwasher. Inquired whether the sanitizing solution is chlorine or quaternary. FSM responded chlorine is not used to sanitize dishware. Requested to review the manufacturer's direction for use (MDFU). FSM was agreeable to contact their contractor for directions and get the MDFU. On 03/30/23 at 12:50 PM, FSM reported the sanitizing solution is chlorine. Inquired when did they identify problems with the dish machine, FSM responded July/August. The dish machine was switched to a low temperature with sanitizing solution on 12/07/22. Requested operator's manual for the dish machine, FSM was agreeable to follow-up with the contractor. On 03/31/23 at 06:50 AM, FSM reported the contractor has provided the facility with strips to test the chlorine-based sanitizing solution. The staff are testing the sanitizing solution at every meal service. Inquired whether staff are documenting the results of the tests. FSM responded this is an ongoing process and currently staff are not documenting the results of chlorine testing. On 03/31/23 at 12:15 PM, requested staff demonstrate the testing of the dish machine's sanitizing chemical. The FSM had the test strips in the office and brought it to the dish machine. The dishwasher tore a strip of the paper, dipped the strip into remnants of clear fluid in a cup, and the color of the strip was matched to the color chart on the container. The dishwasher stated the solution was 100 ppm (parts per million). Queried how many ppm is okay, the FSM was	F 812	times; and cleanliness of the ice machine. All new hire staff will be in serviced at orientation and annually thereafter by the FSM/designee. Refer to policy and procedures for Food Storage, Labeling, and Expiration; Food Supplies Receiving; Ice Machines Proper Maintenance, Cleaning and Sanitation; and Dish Machine Sanitation Verification. 4. The FSM will audit weekly for compliance with Chlorine Sanitizer Test Procedure for Low-Temperature for the dish machine; labeling with date all food items including individual food items; discarding all unlabeled and expired food times; and cleanliness of the ice machine and will report findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 35	F 812		

observed standing behind the dishwasher and heard whispering 50 to 100 ppm.

The FSM reported the sanitizing solution is checked at meal service, three times a day. FSM confirmed the test results of the sanitizing solution was not documented, they just moved to sanitizing solution. FSM reported in December the dish machine was converted to low temperature with chemical sanitization. FSM reported the contractor came on 03/29/23. FSM reported previously water temperatures were being documented. Requested to review the logs of the dish machine temperatures prior to the conversion to low temperature. FSM was agreeable to provide.

On 03/31/23 at 1:25 PM, FSM reported the requested temperature logs for the dish machine was destroyed, it is beyond recognition. FSM provided one-page directions titled, "Chlorine Sanitizer Test Procedures for Low-Temperature Dish machines" from the contractor. A review of the instructions found the dishwasher did not follow the directions for testing the chlorine sanitizer. Step 4 directs tester, "After dipping, let sit for at least 5 seconds but not more than 10 seconds before reading the strip," the dishwasher matched the test strip to the color chart as soon as the strip was removed from the liquid. The instructions did not indicate the designate the acceptable range of the test results. Inquired what are acceptable parameters for the chlorine solution. FSM provided the "Product Specification Document" which noted the final rinse water should be at a concentration of 100 ppm, not to exceed 200 ppm. Also, noted to ensure the concentrations does not fall below 50 ppm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 36 2) On 03/28/23 at 08:30 AM an initial brief tour of the kitchen was done with assistance from the FSM. Observed in the "#2 Walk-in Freezer" a sealed white plastic bag with no label. The FSM was asked what was contained in the bag. FSM responded it may be chicken cordon bleu, then said, it's probably a turnover. FSM commented that the item had expired. The date printed on the bag was 02/16/23. Observation of the "#7 Line Reefer" found a tray with food items (bowls of fruit, pureed bread, pudding). FSM reported he thinks the food items on the tray were from today's breakfast. There was no label on the individual food items and no label on the tray to indicate the food items were from today's breakfast service. Observed there was another tray with food items that was labeled with a date. Asked FSM whether the tray is supposed to be labeled with a date. FSM responded "yes". Observation of the ice machine found brown and gray substances on the white plastic plate above the bin where the ice was stored. The FSM was asked what is that? FSM responded the staff has scrubbed the part and commented they need to replace that part.	F 812		
F 880 SS=D	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	F 880		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure hand hygiene procedures were followed by staff between glove change during a dressing change for one resident (R), R45, and failed to ensure droplet precautions were maintained for another resident, R35, receiving aerosolized medication out of a total sample of 14 residents. These deficient practices encourages the development and transmission of communicable diseases and infections which may affect the health and safety of residents, staff, and visitors. Findings include: 1) On 03/29/23 at 10:15 AM, observed Registered Nurse (RN) 8 while providing care for resident (R)45. RN8 told R45 that she will be	F 880	F 880 Infection Prevention & Control 1. On 04/19/2023 the Director of Nursing educated the RN on the requirement to wash/sanitize hands between glove change during a dressing change. On 04/19/2023 the Director of Nursing educated RN on the requirement to RN that during an aerosol treatment the door should be closed, curtains completely drawn and that staff/visitors entering the room should be fully donned and wearing an N95 mask. 2. On 04/21/2023 the Director of Nursing and Infection Preventionist (IP) observed all staff entering an aerosol treatment room were donned (N95), curtains drawn, doors closed during treatments. The IP observed dressing changes of residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 giving her morning medications through her gastrostomy tube (GT - tube inserted though the belly directly into the stomach) and will also be changing the dressing. RN8 washed her hands in the bathroom sink and donned gloves prior to administering the medications and flushing the GT with water. After flushing the GT, RN8 changed her gloves and removed old dressing to R45's GT site. RN8 changed her gloves again and proceeded to clean the GT site, applied a clear cream to the site and covered it with a new dressing. RN8 did not perform hand hygiene between glove changes. Asked RN8 after she was done if she was supposed to perform hand hygiene after removing gloves and before donning new gloves, RN8 replied, "I'm guessing, yes?" On 03/31/230 at 09:10 AM, interview conducted with the Administrator who also functions as the infection preventionist (IP), and Administrative Assistant (AA) in the conference room. Administrator confirmed that staff were educated to perform hand hygiene between glove changes. 2) On the morning of 03/28/23 during the screening of residents, observed signs posted on the wall next to the doors titled, "Aerosol Contact Precautions". The posting instructed staff and visitors to clean hands when entering and leaving the room, use a NIOSH-approved N95 (respirator), wear eye protection, gown, and glove at door, and keep door closed during procedure. The sign also had an area to document the start time and end time. There was also a posting of two more signs, one with instructions for sequence for putting on PPE and the second for removing PPE. Interviewed Registered Nurse	F 880	to ensure that hand hygiene is being done correctly especially during dressing changes and changing gloves. 3. On 04/19/2023 and 04/20/2023 the IP in serviced all staff on correct hand hygiene especially when changing gloves and during dressing changes. IP in serviced staff on the requirement for drawing curtains, closing doors and donning during aerosol treatments. All new hire staff will be in serviced at orientation and annually thereafter by the Director of Nursing/designee. Refer to policy and procedure on handwashing and aerosol precautions. 4. The infection Preventionist will complete observations/audits on handwashing and precautions used during aerosol treatments each month and will report findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40	F 880		

(RN)2 regarding the reason for aerosol contact precautions and instructions for use of PPEs when visiting residents with aerosol contact precautions. RN2 explained residents with these signs are on hospice and receive duoneb (treatment to open the airways of the lungs, making it easier to breathe) through a nebulizer (machines that change liquid medication into a breathable mist). RN2 explained PPE is required while residents are receiving treatment. RN2 instructed to check for documentation of the start and end time of treatment and if residents are receiving treatment to use PPEs.

On 03/31/23 at 12:38 PM requested to interview the Certified Nurse Aide (CNA) that provides care for Resident (R)35. Staff member assisted in finding CNA8. The staff member located CNA8 in room 116 and called her to come out. CNA8 was observed through the opened door to walk out from behind the privacy curtain of bed A (closest to the window). CNA8 was wearing a procedural mask, not an N95. Observed the aerosol contact precautions sign with documentation of start time of 12:25 PM and end time of 12:40 PM. CNA8 reported she was providing care for R54. CNA8 was asked if she should be wearing a PPE as R18 in bed B (closest to the door) was receiving aerosol treatment. CNA8 responded she does not have to wear PPE as the curtains are closed and was not providing care to the resident receiving treatment.

RN2 came to room 116. RN2 confirmed R18 was receiving aerosol treatment (via nebulizer) and was coming to discontinue the treatment. The engine of the nebulizer machine could be heard running. RN2 was asked whether CNA8 should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41 don PPE as directed by the signage. RN2 reported it was not necessary for CNA8 to wear PPE because the curtain is drawn. Concurrent observation with RN2 found the privacy curtains were drawn to the left and right of R18 with the front opened. CNA8 had to walk past R18's bed to exit the room. RN2 acknowledged the gap in the privacy curtain to the front and commented "it is confusing". On 03/31/23 at 1:31 PM an interview was conducted with the Director of Nursing (DON) via telephone. The DON reported when providing aerosol treatment, staff are to document the start and end time of the procedure and follow the guidelines for use of PPE. DON stated the door is closed before the procedure and the curtains are completely drawn around the resident that is receiving treatment. Inquired whether staff members entering the room during treatment should don PPEs. DON responded that he "didn't think so...PPEs are indicated only for the side where treatment is being provided. DON confirmed the door to the room should be closed during treatment and the curtain completely drawn around the resident's bed.	F 880		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms	F 885		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 42 occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility failed to inform all residents, their representatives, and families of those residing in the facility by 5:00 PM the next calendar day of confirmed cases of COVID-19. This deficient practice fails to appropriately notify the residents and/or their representatives and families of an ongoing COVID-19 virus transmission in the facility. Finding includes: On 03/30/23 at 07:30 AM, Administrator notified the state agency (SA) that on the evening of 03/29/23, two residents and two employees tested positive for the COVID-19 virus. The facility also reported that one employee tested positive for the COVID-19 virus on 03/26/23. An interview was conducted with the Administrator on 03/31/23 at 09:15 AM in the conference room. Asked if residents and their	F 885	F 885 Reporting-Residents, Representatives & Families 1. On 04/11/203 the Assistant Administrator/designee informed the residents, representatives, families by 5 pm the next day following the occurrence of a single confirmed test or 3 or more residents/staff with a new onset of respiratory symptoms occurring within 72 hours of each. 2. On 04/11/2023 the Assistant Administrator informed all of the management, infection Preventionist, staff and clinical clerks of the requirement to inform the residents, representatives, families by 5 pm the next day following the occurrence of a single confirmed test or 3 or more residents/staff with a new onset of respiratory symptoms occurring within 72 hours of each. 3. On 04/19/2023 and 04/20/2023 the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 885	Continued From page 43 families or representatives are notified of the COVID-19 cases in the facility. Administrator responded that they only notified the families and representatives of the residents that tested positive for COVID-19, the ones that came in contact with the COVID-19 positive employees and those that are identified as high risk. Notifications were done the same day. Another weekly notification is sent out for all the residents and their families or representatives every Friday. A second interview was done at 1:34 PM with Administrator in the conference room. Asked if all residents and their families of representatives were notified of the positive cases on 03/26/23 and 03/29/23. Administrator confirmed that only the affected residents' families or representatives were notified and not all residents and their families or representatives were notified by 5:00 PM the next calendar day.	F 885	Infection Preventionist in serviced all of the staff especially the nurses and the clinical clerks on the requirement to inform the residents, representatives, families by 5 pm the next day following the occurrence of a single confirmed test or 3 or more residents/staff with a new onset of respiratory symptoms occurring within 72 hours of each. 4. The Infection Preventionist will audit each month the call logs that all residents, representatives, families were informed by 5 pm the next day following the occurrence of a single confirmed test or 3 or more residents/staff with a new onset of respiratory symptoms occurring within 72 hours of each and will report findings to the QA Committee.	
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		4/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 44 (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 45 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to conduct COVID-19 testing correctly on staff being screened during a COVID-19 outbreak. This deficient practice has the potential to transmit the COVID-19 virus affecting the health and safety of residents, staff, and visitors. Finding includes: On 03/28/23 at 1:02 PM, observations were made of Registered Nurse (RN)1 conducting staff COVID-19 testing to manage an outbreak at the facility. RN1 wore a gown, gloves, face shield, and mask. Staff (S)1 wore a face mask, took off her mask, and did not hand hygiene after touching her mask. S1 swabbed both nostrils, and placed the swab unto the COVID-19 testing card and closed it. S1 did not hand hygiene after touching the COVID-19 testing card. S2 wore a face mask, pulled down her face mask by touching the front and pulling it down to her chin. S2 did not perform hand hygiene after touching her mask. S2 swabbed both nostrils, and placed the swab unto the COVID-19 testing card and sealed it closed. S2 did not hand hygiene after touching the COVID-19 testing card and repositioned her eyeglasses on her face as she walked away from the table where she conducted her COVID-19 self-test. S3 sat down at a table, removed her mask, and did not hand hygiene after touching her mask. S3 swabbed both	F 886	F 886 Covid-19 Testing Residents & Staff 1. On 04/04/2023 the Director of Nursing educated the Covid-19 testing RN that staff must wash their hands after taking off the mask, after completing the test, and after replacing the mask. 2. On 04/04/2023 the Director of Nursing educated all testing RNs that staff must wash their hands after taking off the mask, after completing the test, and after replacing the mask. 3. On 04/19/2023 and 04/20/2023 the Director of Nursing/designee in serviced all staff that during Covid-19 testing that each must wash their hands after taking off the mask, after completing the test, and after replacing the mask. All new hire staff will be in serviced at orientation and annually thereafter by the Infection Preventionist/designee. 4. The Infection Preventionist will audit monthly that during Covid-19 testing that staff wash their hands after taking off the mask, after completing the test, and after replacing the mask and report findings to the QA Committee. Each area will be reviewed by the Quality Assurance Committee quarterly until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 46	F 886		

nostrils, placed the swab on the COVID-19 testing card and closed the card. S3 did not hand hygiene before leaving the testing area.

On 03/28/23 at 1:30 PM, RN1 was asked if she instructed the staff to hand hygiene before and after performing their self-test and she stated, "No."

Reviewed the "BinaxNOW COVID-19 Ag [antigen] CARD" obtained from the box of BinaxNOW COVID-19 test kits. Under "PRECAUTIONS," it stated, "... 16...patient samples, controls, and test cards should be handled as though they could transmit disease. Observe established precautions against microbial hazards during use and disposal." Under "SPECIMEN COLLECTION and HANDLING," it stated, ... Refer to the CDC [Centers for Disease Control and Prevention] Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19) https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html.

Reviewed the CDC's "How to Collect an Anterior Nasal Swab Specimen for COVID-19 Testing" poster from the aforementioned link leading from "... Key Points ... Guidance for self-collection of specimens can be found here ..." It stated, "Set up 1. Disinfect the surface where you will open the collection kit. Remove and lay out contents of kit. Read instructions before starting specimen collection. 2. Wash hands with soap and water. If soap and water are not available, use hand sanitizer." Under "... Preparation of specimen for return ... 8. Place the swab in the sterile tube... 9. Wash hands or re-apply hand sanitizer." Under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125059	A. BUILDING _____ B. WING _____	03/31/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 47 "... Returning the specimen and clean-up ... 12. Throw away the remaining specimen collection kit items. 13. Wash hands or re-apply hand sanitizer."	F 886		