STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Honolulu, LLC	1930 Kamehameha IV Rd Honolulu, HI 96819

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4) On 03/31/25 at 10:15 AM, observed R36 resting in her room in her bed. Observed call light was hanging from the side of her bed, out of reach for the resident. On 04/02/25 at 09:23 AM, observed R36 in her bed sleeping. Observed R36's call light was on the ground. At this time interviewed CNA and inquired if resident's call light is to be within reach of resident and she confirmed this, stated they (staff) leave the call light near the resident before leaving the resident. CNA cleaned the cord and call light with a wipe and placed on resident's bed. Call light was not attached to R36's blanket to prevent it from falling onto the floor again. 5) On 03/31/25 at 02:30 PM, an interview was done with R136 in her room at the bedside. R136 was observed lying on her call light cord. Inquired of R136 why her call light cord was behind her back and she stated she puts it there to make sure it will not fall on the ground because she will have to reach down to pick it up which she explained would be hard for her do. On 04/01/25 at 09:54 AM a dressing change was observed for R136 of her right foot and at this time R136 was seen with her call light cord placed behind her on her bed. 6) On 03/31/25 at 09:30 AM, observed R39 in his room in bed resting. Observed R39's call light was on a wooden shelf behind his bed. On 04/02/25 at 09:05 AM, observed R39 asleep in his bed. Observed R39's call light was on the ground next to resident's bed. Inquired of RN94 where R39's call light should be and she said near the resident. RN94 picked up R39's call light from the ground and placed it near the resident on his bed. Call light was not attached to R39's blanket to prevent it from falling onto the floor again. On 04/03/25 at 10:37 AM, an interview was done with (Director of Nursing) DON in the Administrator's office. Inquired of resident's call light and she confirmed the call light is to be within reach for the resident who is left in their room in bed. Shared observation that a resident's (R39) call light was observed on the wooden shelf behind his bed and she stated she knew which resident surveyor was speaking of because he is the only one who has the wooden shelf behind his bed. Inquired if the call lights can be clipped to the sheet so that it does not fall to the ground and DON stated she has gotten clips for the call lights and had them passed out. Based on observations, interviews, and record reviews, the facility failed to accommodate the needs of six of six sampled residents (Residents (R) 19, R54, R338, R36, R136 and R39) by not ensuring that call devices were placed within residents' reach and positioned so the residents could activate them. As a result of this deficient practice the residents were placed at risk of not having their (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emergent needs met in a timely manner and prevented them from achieving independent functioning with regards to calling for help. This deficient practice has the potential to affect all the residents in the facility who can activate a call light. Findings include: 1) R19 is an [AGE] year-old female, admitted to the facility on [DATE]. A review of R19's electronic health record (EHR) noted diagnoses of, but not limited to, legal blindness and Parkinson's with dementia. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/15/25 noted that R19 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated that R19 had intact cognitive function. On 03/31/25 at 08:40 AM, R19's call device cord was observed to be wrapped around the bed rail, located on the upper right side of R19's bed, with the call button portion of the device facing downward against the side of the bed. R19's bilateral arms were observed to be bent at the elbows with her hands positioned near her face. Placement of the device was out of her reach. On 03/31/25 at 02:25 PM, observed call device placement on the right edge of R19's bed. R19's bilateral arms observed to be bent at the elbows. R19 was unable to straighten her right arm on request and stated that she cannot move her left arm. Placement of the device was out of her reach. On 04/01/25 at 07:16 AM, observed call device cord wrapped around the right upper bed rail with the call button facing downward against the side of the bed. Registered Nurse (RN) 9 was interviewed and stated that R19 holds the call device but does not press it, however, she should still have access to it. On 04/02/25 at 07:33 AM, observed call device placement on the right edge of R19's bed. Placement of the device was out of R19's reach. On 04/03/25 at 07:05 AM, observed call device cord wrapped around the right upper bed rail with the call button facing downward against the side of the bed. Placement of the device was out of R19's reach. 2) R54 is a [AGE] year-old male admitted to the facility on [DATE]. A review of R54's EHR noted diagnoses of, but not limited to, metabolic encephalopathy (impaired brain function due to chemical imbalance), fracture of thoracic 11 - thoracic 12 vertebra (middle section of the spine), and muscle weakness. An admission MDS with an ARD of 03/04/25 noted that R54 had a BIMS score of 15, which indicated that R54 had intact cognitive function. On 04/01/25 at 07:23 AM, observed the call device at the top of a pillow located at R54's head of bed. State Agency (SA) asked R54, What do you do when you need help? R54 answered that he rings the call bell. SA then asked if he could demonstrate how to use it. R54 was unable to locate the call device and it was out of his reach. On 04/01/25 at 07:28 AM, RN19 was interviewed near R54's bed and stated that R54 is sometimes able to use the call device and sometimes is not able. RN19 confirmed the call device was not within R54's reach and proceeded to give it to him. 3) R338 is an [AGE] year-old female admitted to the facility on [DATE]. A review of R338's EHR (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted diagnoses of, but not limited to, closed supracondylar fracture of left humerus (a break in the upper arm bone, located just above the elbow joint), history of falls, chronic pain of both knees, and osteoporosis (disease that weakens bones). A MDS with an ARD of 03/17/25 noted that R338 had a BIMS score of 14, which indicated that R338 had intact cognitive function. On 04/01/25 at 09:47 AM, observed Certified Nurse Aide (CNA) 50 assisting R338 in her bed. When CNA50 left R338's room, observed R338's call device located above her pillow at the head of her bed. Asked R338, When you need help, how do you call the staff? R338 answered that she presses the call button. Requested R338 to show the call device and resident unable to locate it. On 04/01/25 at 10:04 AM, CNA50 was interviewed outside of R338's room. CNA50 stated that R338 should have the call device on her chest and made sure R338 had it before she left the room. Observed CNA50 then go into R338's room and ask R338, Where is your call bell? Observed R338 move her right hand around the bed until she found the call device cord and proceeded to pull the cord until she reached the call button. Placement of the call device was out of her reach. On 04/02/25 at 02:15 PM, a review of the facility policy titled, Resident Call System noted under the section titled, Guidelines: 3. The call system will be accessible to residents while in bed other sleeping accommodations within the resident room .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation and interview, the facility failed to ensure personal information was protected for one of one randomly sampled resident (Resident (R) 88). The Electronic Health Record (EHR) was left open. As a result of this deficient practice, residents are at risk of their health information not remaining private. Findings include: On 04/02/25 at 07:40 AM, observed station one's medication cart in the hallway. The EHR on the cart was left open and R88's list of medications was visible and was not protected. On 04/02/25 at 07:45 AM, interviewed Registered Nurse (RN) 81 on what their policy is for the EHR, RN81 replied, I'm sorry, I forgot to close it. It should be locked every time we walk away.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the comprehensive resident assessment accurately reflected the resident's status for one of 21 residents sampled (Resident (R) 77) for accuracy of assessment. R77's admission comprehensive assessment did not include oxygen (O2) therapy as a respiratory treatment R77 was receiving at the facility. As a result, R77's O2 therapy was not care planned, O2 physician orders were not reviewed, and her O2 tubing was overlooked. Findings include: Cross reference to F695, Respiratory Care. The facility failed to ensure R77's respiratory care was consistent with professional standards. R77's O2 tubing was not labeled with the date it was last replaced and the physician orders did not include parameters and delivery method. Cross reference to F656, Development of the Care Plan. The facility failed to ensure R77's comprehensive care plan included O2 therapy. Review of R77's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/25 under Section O. Special Treatments, Procedures, and Programs, O2 was not checked off as a treatment performed on admission. On 04/02/25 at 02:06 PM, an interview and concurrent record review with MDS Director (MDSD) 67 and MDSD43 was done. The MDSDs reported if a resident has O2 therapy, it would be documented in the MDS under Section O. MDSD67 confirmed R77 had O2 therapy when the admission assessment was completed and it should have been documented on R77's admission MDS, ARD 03/04/25, Section O. MDSD67 confirmed it was not done.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on interviews and record review, the facility failed to furnish a copy of the baseline care plan (BCP) for one of two residents (Resident (R) 385) sampled for care plan meetings. The facility not providing the BCP to the residents does not keep them informed of the initial plan for delivery of care and services residents are to receive. Findings include: On 04/01/25 at 12:10 PM, interview with R385 completed. R385 stated doing ok and has plans to go home on Monday. R385 has been at facility for about a week with right leg injury and has been getting physical therapy and occupational therapy and stated it has been manageable. When asked if the facility discussed with him his plan of care, he responded no. He also stated he did not receive a copy of his care plan. On 04/01/25 at 01:00 PM, record review of R385's electronic health record (EHR) did not show that he was given a copy of his baseline care plan (BCP). On 04/02/25 at 10:00 AM, interview with Director of Nursing (DON) completed. DON stated that the care plan discussion was done at the welcome meeting with the Interdisciplinary Team (IDT). DON provided a copy of the IDT Care Plan Conference/Welcome Meeting Form, which showed that R385 and his wife was in attendance. When asked if the resident was provided a copy of his care plan, she responded, not that I see in the chart.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews the facility failed to develop a person-centered comprehensive care plan for one of two residents (Resident (R) 77) sampled for respiratory, one of two residents (R390) sampled for dialysis, and one of one resident (R387) sampled for catheter care. As a result of this deficient practice, staff did not have the information necessary to adequately care for R77's oxygen (O2) therapy, R390's dialysis needs and post-treatment, and R387's catheter care. Findings include: 1) Cross tag to F695, Respiratory Care. The facility failed to ensure R77's respiratory care was provided consistent with professional standards. R77's O2 tubing was not labeled with the date it was last replaced and the physician orders did not include parameters and delivery method. On 04/02/25 at 02:06 PM, an interview and concurrent record review with MDS Director (MDSD) 67 was done. MDSD67 confirmed R77's comprehensive care plan did not include O2 therapy. MDSD67 reported if a resident was admitted to the facility with O2 therapy, nursing staff or the MDS staff would input it in the care plan. On 04/02/25 at 04:07 PM, an interview with Director of Nursing (DON) was done. DON confirmed R77 should have had a care plan for her O2 therapy, and the care plan would include the physician orders. Review of the facility's policy and procedure regarding respiratory care, number 695, dated 07/2018, documented, The resident's individualized care plan will identify the interventions for oxygen therapy, based on the resident's assessment and orders, such as, but not limited to: i. Type of oxygen delivery system; ii. When to administer, i.e. [for example] continuous or intermittent and/or when to discontinue; iii. Equipment setting for the prescribed flow rates; iv. Monitoring of SpO2 [oxygen saturation] levels and/or vital signs, as ordered; and v. Monitoring for complications i.e. skin integrity issues related to the use of a nasal cannula. 2) Cross reference to F698, Dialysis. On 04/02/25 at 09:00 AM, observed R390, who was admitted to the facility on [DATE], right upper arm fistula pressure dressing still on from yesterday's Hemodialysis (HD) treatment. R390 also stated that staff will take it off when they have time and don't really check for the thrill and bruit. On 04/02/25 at 9:30 AM, record review of R390's care plan noted a focus on HD that was initiated on 03/20/25, with interventions to monitor, document, and report as needed any signs and symptoms of infection to access site redness, swelling, warmth or drainage, but did not include intervention to assess access site for thrill and bruit. The Treatment Administration Record (TAR) showed the dialysis fistula checks for thrill and bruit were being done every shift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 10:00 AM, interview with DON confirmed that they should be checking for the thrill and bruit before and after dialysis and every shift. Asked DON to show R390's care plan to see if there were interventions of checking for the thrill and bruit and confirmed it was not included in the resident's care plan but was noted in physician's orders. DON proceeded to add the interventions to care plan. 3) On 03/31/25 at 11:00 AM, observed R387 with indwelling catheter, secured to right leg, draining clear yellow urine, covered with bag, but bag noted on the floor without any barrier. Concurrent interview with R387, stated he came in without a catheter but asked for one because he was having a hard time urinating standing up. R387 was admitted to the facility on [DATE]. On 04/02/25 at 08:23 AM, record review of R387's minimum data set (MDS) bladder/bowel section noted that R387 is always continent. Review of progress note dated 03/26/25, stated bladder scan and straight cath [cathetor] every shift. R387 had 600 milliliters (ml) of urine retention on scan, indwelling catheter was inserted. Physician's orders dated 03/26/25 noted to insert foley catheter for urinary retention. Review of comprehensive care plan found no catheter focus, goals, and interventions. On 04/02/25 at 11:00 AM, interview with DON, verified that R387 was having retention issues as much as 600 ml of urine retention on bladder scan and so indwelling catheter was inserted on 03/26/25. Asked DON to review care plan and DON confirmed that there was no catheter care initiated and should have been added in the plan of care. Review of the facility's Comprehensive Care Plans policy, dated 11/2017, in the guidelines section, it stated The care plan will be comprehensive and person-centered. It will drive the type of care and services that a resident receives and will describe the resident's medical, nursing, physical .needs and preferences; as well as how the facility will assist in meeting these needs and preferences. In the Policy section, it also stated, The facility interdisciplinary team (IDT) will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, physical .that are identified in the comprehensive assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to update Resident (R) 136's care plan to include a new intervention to treat resident's moisture-associated skin damage (MASD) with an antifungal once identified, for one of four residents sampled for skin conditions (non-pressure). The deficient practice put R136 at risk for worsening of fungal infection with MASD to her sacrum and buttocks which could lead to a pressure injury and pain. Findings include: Cross reference to F684, Quality of Care - Despite identifying R136 had a fungal infection and MASD to her sacrum and buttocks, that had worsened since admission, the facility failed to acquire a physician order for antifungal to treat the area and update R136's care plan.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to care plan and implement residents' individual activity preferences and accommodate special needs for two of two residents (Resident (R) 19 and R338) sampled for activities. This deficient practice has the potential of not supporting the physical, mental, and psychosocial well-being of residents and not creating a meaningful life for residents residing in the facility. Findings include: 1) R338 is an [AGE] year-old female admitted to the facility on [DATE]. A Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/25 noted that R338 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated that R338 had intact cognitive function. On 04/01/25 at 09:45 AM, R338 stated that no one comes to her room to offer activities and feels bored. She also stated that she cries when she is bored and proceeded to cry. A facility notice posted in the main elevator stated, Group Activities and Dining has been cancelled due to Covid in the facility. Recreation services will provide daily temporary 1:1 in room visits . On 04/02/25 at 08:41 AM, Recreation Director (RD) 1 was interviewed and stated that since approximately 02/26/25 group activities in the facility were cancelled because of Covid. In its place, one-on-one in-room activities were being provided. On 04/01/25 at 02:39 PM, a review of R338's recreation care plan, with a start date of 03/12/25, did not list one-on-one in-room visits as an intervention. A review of R338's MDS, Section F: Preferences for Routine and Activities, with an ARD of 03/17/25 noted: Question D. How important is it to you to keep up with the news? Answer marked 1. Very important. Question F. How important is it to you to participate in religious activities? Answer marked 1. Very important. Question G. How important is it to you to go outside to get fresh air? Answer marked 1. Very important. Question H. How important is it to you to participate in religious activities? Answer marked 1. Very important. The resident preferences above were not listed on the recreation care plan dated 03/12/25. On 04/01/25 at 03:03 PM, a review of an assessment form used by the Recreation department titled, ACT My Ways -V3, completed on 03/12/25 11:27 AM, contained question number 30: Activities has met and reviewed resident activity preferences not marked as completed. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 08:41 AM, RD1 was interviewed in the dining room. RD1 reviewed R338's care plan, with a start date of 03/12/25, and confirmed that no intervention for one-on-one activities in the resident room was listed. RD1 also confirmed that the activities noted as very important by R338 on the MDS, Section F: Preferences for Routine Activities, with an ARD of 03/17/25, was also not listed on the care plan. RD1 confirmed that question number 30: Activities has met and reviewed resident activity preferences on the ACT My Ways -V3 form completed on 03/12/25 at 11:27 AM was not completed. RD1 stated that marking the box as complete for question number 30 means activity preferences were reviewed with the resident. RD1 proceeded to say that she does not complete question number 30 because when the form is submitted, there is no pop-up message indicating the question was not completed and therefore, assumed that not completing it was okay. RD1 also stated that she is unable to bring R338 outside to get fresh air because all the residents cannot currently go out from their room, and if one resident is brought outside, that would be unfair to the other residents. RD1 stated that she did not ask Administration at the facility if providing one-on-one activities outside of the residents' rooms were allowable and was not doing that currently. During the interview with RD1 in the dining room, residents were observed receiving one-on-one therapy by the facility's Rehab Therapy staff. On 04/02/25 at 01:00 PM, a Point of Care (POC) Response History document noting one-on-one activities completed with R338 from 03/13/25 - 04/02/25 was reviewed. Activities noted as very important to R338 on the MDS, Section F: Preferences for Routine Activities, with an ARD of 03/17/25 were not found on the POC Response History document. 2) R19 is an [AGE] year-old female, admitted to the facility on [DATE]. A review of R19's EHR noted that she was blind. A MDS with an ARD of 02/15/25 noted that R19 had a BIMS score of 15, which indicated that R19 had intact cognitive function. On 04/02/25 at 11:43 AM, RD1 was interviewed with a concurrent review of R19's care plan dated 03/03/25 and POC Response History document noting one-on-one activities completed for R19 from 03/06/25 - 04/01/25 (27 days). RD1 stated that to accommodate R19's blindness, activities provided include sensory stimulation, scents, hand massage, trivia, and playing music/listening to the radio. RD1 acknowledged that those activities were not and should have been listed in the care plan. Upon review of the POC Response History document with RD1, Cards/Board Games/Puzzles was marked as being done 1 of 27 days. SA questioned RD1 on how the resident was able to participate in that activity due to her blindness. RD1 responded that trivia was conducted verbally. The POC document also noted Providing Leisure Supplies was marked as done 4 of 27 days. RD1 defined this category as providing music/radio for R19 to listen to. RD1 stated that providing more of the one-on-one activities she identified to accommodate R19's blindness should have been implemented. On 04/02/25 at 02:25 PM, a review of the facility policy titled, Activities noted under the section titled, Guidelines: 4. The activity program .are designed to meet the assessed needs and interests of each resident ., 5. Activity programs are provided in coordination with the resident's comprehensive assessment, functional ability, and preferences.

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	125020	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) Cross reference to F657 Care Plan Timing and Revision - Despite identifying worsening of R136's MASD with a fungal infection to her sacrum and bilateral buttocks the facility failed to update R136's care plan and aquire a physician order for an antifungal to treat R136's fungal infection from 03/29/25 until 04/03/25. On 03/31/25 at 03:09 PM, an interview was held with R136 at her bedside. Inquired with R136 if she had any skin breakdown such as rash or pressure injury to her back and buttocks and she confirmed she had MASD to her bottom and rash on her back which she explained was from a reaction she had from the adult briefs. R136 explained facility staff switched out the adult briefs for the pull up type and she stated her rash was getting better. On 04/03/25 at 10:24 AM, record review of R136's electronic health record (EHR) revealed R136 is a [AGE] year-old female who was admitted to the facility on [DATE] and her diagnoses include, but are not limited to, encounter for orthopedic aftercare following surgical amputation, type 2 diabetes mellitus with hyperglycemia, and other specified soft tissue disorders. Reviewed documentation of resident's skin assessments with pictures which revealed resident's MASD had gotten worse since admission. First wound evaluation of R136's MASD was done on 03/14/25 at 19:11 (07:11 PM). Dimensions documented included area at 21.3 cm² (centimeter), length 9.57 cm and width 4.69 cm. Continued record review found second wound evaluation dated 03/26/25 at 12:53 PM of R136's MASD revealed it had gotten worse, no measurements were included in this documentation but a picture was. The Woundcare Nurse Registered Nurse (RN) 24 documented under Progress section notes Resident reports itchiness to brief. Switched resident to pull upbrief (sic.) 3/25/25, resident reports relief of itchiness. Resident with fan in room to help circulate air. RN24 documented the practitioner was notified along with resident/responsible party. RN24 documented under Treatment section Dressing Appearance None Cleansing Solution Normal Saline Debridement None Primary Dressing Antifungal Secondary Dressing No secondary dressing Modalities None Additional Care Moisture barrier, Moisture control. Continued record review found third wound evaluation of R136's MASD was done on 04/01/25 which included the following dimension measurements area 122.22 cm² +473 %, length 24.67 cm +158 % and width 23.18 cm +394 %. Below this box of measurements included the following statement *Negative percentage values indicate wound is getting smaller. R136's measurements included positive percentages which indicates the wound was getting bigger. Continued review of R136's EHR revealed she had an order for Moisture-associated skin damage (MASD) to her sacrum extending to her bilateral buttocks that was being treated by Apply Triad Paste cleanse with NSS [Normal Saline Solution] and pat dry before application every shift for 14 days *[W1] Indicate status to surrounding skin (I)ntact (E)rythmatous (M)acerated *[W2] Assess for s/sx [signs and symptoms] of infection or other complication (+) Complication noted, notify MD (-) No complication noted. Order start date 03/14/25 at 2300. This treatment was stopped on 03/28/25 with the last entry of treatment on 03/28/25 Eve1. After this treatment there were no other physician orders found to treat R136's MASD to her sacrum and her bilateral buttocks on 03/29/25 - 04/03/25 at 10:24 AM. Concurrent record review of R136's care plan did not include any updates to treat R136's MASD with an antifungal. Focus (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident has MASD to sacrum r/t [related to] incontinence Date Initiated: 03/18/2025 Revision on: 03/18/2025 Goal The resident's MASD will heal by review date. Date Initiated: 03/18/2025 Revision on: 03/27/2025 Target Date: 06/14/2025 Interventions/Tasks Avoid scratching and keep hands and body parts from excessive moisture. Date Initiated: 03/18/2025 Increase out of bed activity as tolerated. Date Initiated: 03/18/2025 On 04/03/25 at 10:37 AM, interviewed DON in the Administrator's office. Inquired about R136's MASD which had gotten worse since admission. DON stated resident has Baza ordered (antifungal cream) for MASD to apply every day and evening shift. Subsequent to the interview with the DON, on 04/03/25 at 11:59 AM, reviewed R136's orders and found an order for Baza Antifungal External Cream 2% had been ordered for R136 on 04/03/25 at 11:07 AM and an update to the care plan that included The resident has MASD to sacrum with fungal rash r/t incontinence and Interventions/Tasks Apply tx [treatment] as ordered by MD. Date Initiated: 04/03/2025. R136 had not received treatment from 03/29/25 till 04/03/25, after DON was interviewed by surveyor about resident's MASD worsening. Focus The resident has MASD to sacrum with fungal rash r/t incontinence Date Initiated: 03/18/2025 Revision on: 04/03/2025 Goal The resident's MASD will heal by review date. (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 03/18/2025 Revision on: 03/27/2025 Target Date: 06/14/2025 Interventions/Tasks Apply tx as ordered by MD. Date Initiated: 04/03/2025 Based on record review and interviews, the facility failed to provide resident centered needed care and services for two of six residents (Resident (R) 77 and R136), R77 who was one of one sampled for constipation/diarrhea and R136 who was one of four residents sampled for skin conditions (non-pressure). The facility did not follow the physician ordered bowel regimen for R77. This deficient practice put R77 at potential risk for discomfort and fecal impaction. The facility failed to treat R136's Moisture-associated skin damage (MASD) with fungal infection to her sacrum and to her bilateral buttocks from 03/29/25 until 04/03/25 which the facility identified as worsening. This put R136 at risk for harm from possibly developing a pressure injury and pain. Findings include: 1) R77 was admitted to the facility on [DATE] with diagnosis of, not limited to, constipation. Review of R77's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/25, assessed R77's Brief Interview of Mental Status (BIMS), a 14 out of 15 (cognitively intact). Review of R77's person-centered comprehensive care plan documented The resident has constipation or potential for constipation r/t [related to] decreased mobility, pain, narcotic medication use for pain .The resident will have a normal bowel movement at least every 1-2 days through the review date .Administer stool softeners as per orders. Monitor for side effects and effectiveness .Monitor/document/report PRN [as needed] s/sx [signs/symptoms] of complications related to constipation .Record bowel movement pattern each day. Describe amount, color and consistency. On 04/01/25 at 11:03 AM, an interview with R77 was done. R77 reported she gets constipated often for about three or more days. R77 stated she finds it difficult to make a bowel movement sometimes even with the routine medications for her bowel movement. Review of R77's physician ordered bowel regimen included MiraLAX powder (polyethylene glycol 3350) give 17 grams by mouth, mix with 4-8 ounces of water or juice, two times a day for constipation; Sennosides-Docusate Sodium oral tablet 8.6-50 milligrams (mg.), give two tablets by mouth two times a day for constipation; MiraLAX powder give 17 grams by mouth, mix with 4-8 ounces of liquid, as needed for no bowel movement results in three days; and Dulcolax suppository (bisacodyl) insert 10 mg. rectally as needed for no bowel movement results from MiraLAX, notify doctor if ineffective. Review of R77's daily recorded bowel movement in the Electronic Health Record (EHR) found R77 did not have a bowel movement from 03/16/25 to 03/18/25 (three days), 03/20/25 to 03/24/25 (five days), and 03/30/25 to 04/01/25 (three days). (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 03:56 PM, a concurrent record review and interview with Director of Nursing (DON) was done. DON reported the EHR would trigger on the resident's dashboard if a resident did not have a bowel movement for three days to notify the nurse to administer any as needed bowel regimen medication. Concurrent review of R77's daily recorded bowel movement, DON confirmed R77 did not have bowel movements on 03/16/25 to 03/18/25, 03/20/25 to 03/24/25, and 03/30/25 to 04/01/25. DON stated R77 should have gotten the prescribed as needed MiraLAX on 03/18/25, on 03/22/25, and on 04/01/25, and confirmed through review of R77's Medication Administration Record (MAR) that she was not administered the medications on those days. Review of the facility's bowel program guidelines dated 12/02/20 included: 1. Bowel movement frequency will be assessed daily by the nurse. 2. Resident assessed as having inadequate bowel function manifested by absence of regular bowel movement in excess of three days will be assessed by the nurse . 3. When needed, a bowel protocol will be implemented as established by physician's orders .

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	125020	A. Building B. Wing	04/03/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure one of three residents (Resident (R) 29) sampled for limited range of motion (ROM) received the appropriate treatment, equipment, and services to maintain and/or prevent a decline in ROM, as evidenced by inconsistent application of splint and ROM exercises. This puts R29 at risk of a decline in ROM and further contractures. Findings include: Cross reference to F725, Sufficient Nursing Staff. The facility failed to ensure sufficient nursing staff were available to ensure restorative nursing assistance was provided. R29 was admitted to the facility on [DATE] with diagnoses, not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness or paralysis on left side of the body) and neuralgia and neuritis (nerve inflammation or damage). R29's room was under Transmission Based Precautions (TBP), Droplet Precautions, due to her roommate with positive COVID-19 from 05/25/25 to 04/05/25. On 03/31/25 at 02:02 PM, observed R29 in bed her left arm was folded with fisted hand on chest and no splint. On 03/31/25 at 02:29 PM, an interview with R29's Resident Representative (RR) 2 was done. RR2 reported the facility is supposed to assist R29 with exercises and stretches to left knee, arm, and hand but does not think they have done it in a while. On 04/02/25 at 08:15 AM, observed R29 eating breakfast (assistance with staff) in bed her left arm was folded with fisted hand on chest and no splint. At 11:34 AM, observed R29 in bed her left arm was folded with fisted hand on chest and no splint. Review of R29's electronic health record (EHR) found R29 has a passive range of motion (PROM) and active range of motion (AROM) program with assistance from Restorative Nurse Aides (RNA) initiated on 02/17/25. The physician order for PROM includes the RNA to provide PROM exercise to left upper extremity (LUE) with gentle stretching to bilateral lower extremity (BLE) three sets of 10 repetitions seven times a week as tolerated. For AROM, R29 to be encouraged to due right upper extremity (RUE) exercises using two-pound (lbs.) dumbbell three sets of 10 repetitions four times a week (Monday, Wednesday, Thursday, Friday) as tolerated. R29's EHR further found R29 has a physician order for splint to left hand and left elbow and splint to left knee. R29's care plann specified her splint program documenting, RNA to assist with applying left elbow splint and left hand grip orthosis up to 4-6 hours (On: 6am off: 10am-12p) and left ankle brace x3 hours (on 6am, off: 9am) daily as tolerated. Review of documentation of R29's PROM, AROM, and splint program provided from 03/25/25 to 04/02/25 documented R29 did not receive RNA services on 03/26/25, 03/27/25, and from 03/29/25 to 04/02/25. R29 only received services once during that sampled time, on 03/28/25. On 04/03/25 at 08:31 AM, observed R29 eating breakfast with assistance from Certified Nurse Aide (CNA) 75, in bed her left arm was folded with fisted hand on chest and no splint. Inquired with CNA75 if R29 has a splint for her hand and knee, CNA75 reported R29 should be wearing her splint daily but (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. Building B. Wing	04/03/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility did not have an RNA today. CNA75 proceeded to explain that she could put the splint on. Inquired with R29 in her native language, Korean, if the facility had been helping her with exercises and stretches, she stated no and that she would like to continue her exercises and stretches. On 04/03/25 at 08:37 AM, interview with MDS Director (MDSD) 67 was done. MDSD67 confirmed she oversaw the RNA program and R29 receives services daily. RNA reported that R29's services should continue even under TBP and that she may not be getting services due to RNA staff called to floor as CNA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation and interview the facility failed to provide an environment free of accident hazard for one of two sampled resident (Resident (R) 25) observed for accidents. R25 was observed pushed in her wheelchair with her leg rests not in place putting the resident at risk for an accident that could result in harm. Findings include: On 03/31/25 at 10:43 AM, R25 was observed pushed in her wheelchair by Physical Therapy Assistant (PTA) 5 and Occupational Therapy Assistant (OTA) 7 from the end of the hall to the hallway where her room is located. R25 was seen pushed without her leg rests on her wheelchair and observed holding her feet up. Surveyor stopped staff and asked PTA5 and OTA7 where resident's leg rests were for her wheelchair. PTA5 stated they were crunched for time and leg rests are in her room. PTA5 and OTA7 proceeded to R25's room. On 03/31/25 at 10:46 AM, interviewed Physical Therapist (PT) 1 who was in the hallway outside of R25's room. Inquired of PT1 what rehab staff are to do with the foot rests for residents who are receiving PT services. PT1 explained there is a holder on the back of the wheelchair where you can place the foot rests. PT1 and surveyor went into R25's room and inquired with R25 if we could look at the wheelchair she was sitting on. PT1 was able to move R25's wheelchair and saw there is no holder on the back of R25's wheelchair. Inquired with PT1 if this is something they can request to have put onto the wheelchair since PT1 identified the wheelchair as belonging to the facility. PT1 confirmed this is something the facility can order and put on the back of the wheelchair. Inquired how staff manage the foot rests when they are working with the residents and PT1 explained staff will work with the residents and have them walk and then the staff will go back to the room and get the foot rests when they are needed. PT1 explained it might be hard for residents without good cognition to keep their feet up when wheelchair is being pushed and some residents are weak and cannot keep their feet up. On 04/02/25 at 09:45 AM, inquired with OTA7 where R25 was located when they started pushing resident in her wheelchair and OTA7 stated the gym on the first floor. At this time asked Director of Nursing (DON) to measure the distance from the gym to the resident's room. The gym to the elevator on the first floor was 39 feet (ft.) and from the elevator on the second floor to resident's room was 107 ft. which is a total of 146 ft. R25 was pushed in the wheelchair without the leg rests. On 04/03/25 at 12:49 PM, interviewed Director of Rehab (DOR) in the first floor gym. DOR stated she is also a physical therapist. She confirmed staff should have had leg rests on the wheelchair when pushing a resident in their wheelchair. DOR stated staff receive training on safety when working with residents.

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	125020	A. Building B. Wing	04/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) On 03/31/25 at 10:50 AM, observed R10 sleeping in her bed with her oxygen concentrator on and resident wearing a nasal cannula. Observation of oxygen tubing from the oxygen concentrator attached to the nasal cannula and tubing from the sterile saline to the oxygen concentrator did not have any marking to identify the date they were initiated. On 04/02/25 at 09:11 AM, observed R10's oxygen tubing, from the oxygen concentrator attached to the nasal cannula and tubing from the sterile saline to the oxygen concentrator, which now had an orange sticker dated 03/29/25 and timed at 0700 (07:00 AM) which stated, Change Saturday. On 04/03/25 at 09:49 AM, interviewed DON in the Administrator's office. Inquired why staff would back date a resident's oxygen tubing. Surveyor shared observation that occurred on 03/31/25 of a resident's oxygen tubing that had been observed with no sticker identifying when the tubing was initiated and then second observation, of same resident, that tubing was labeled with a Change Saturday sticker with a 03/29/25 date. Inquired of DON why staff would do this and she was not able to explain why. DON confirmed tubing is to be changed out every Saturday. Based on observations, interviews, and record reviews, the facility failed to ensure respiratory care was provided consistent with professional standards for two of two (Resident (R) 77 and R10) sampled for respiratory. R77's comprehensive assessment did not include oxygen (O2) therapy, it was not included in her care plan, her nebulizer and O2 tubing was not labeled with the date it was last replaced and the physician O2 orders did not include parameters and delivery method. R10's O2 tubing was not labeled with the date it was last replaced. This deficient practice put R77 and R10 at risk for respiratory complications. Findings include: 1) Cross reference to F641, Accuracy of Assessments. The facility failed to ensure R77's comprehensive assessment reflected she had O2 therapy. Cross reference to F656, Development of the Care Plan. The facility failed to ensure R77's comprehensive care plan included O2 therapy. R77 was admitted to the facility on [DATE] with diagnoses of, not limited to, cough, allergic rhinitis, and asthma. Review of R77's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/25, assessed R77's Brief Interview of Mental Status (BIMS), 14 out of 15 (cognitively intact). Under Section O. Special Treatments, Procedures, and Programs, O2 was not checked off as a treatment performed on admission. Review of R77's hospital discharge summary prior to admission to the facility dated 03/03/25 documented diagnosis of possible reactive airway disease versus chronic obstructive pulmonary disease. On 03/31/25 at 09:45 AM, during an initial observation and interview with R77, R77 reported she had the nebulizer (a machine that turns liquid medicine into a mist that can easily be inhaled, connected to a facemask) and O2 therapy since she was admitted to the facility. She reported the facility (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not changed the tubing for the nebulizer or O2 since she received them, and that the facility did not label the tubing. Observed O2 tubing and nebulizer with no label indicating the date the tubing was last replaced. The O2 concentrator was on, and the flow rate was 2.5 liters per minute (LPM) and R77 was observed to utilize the nasal cannula (a device that delivers extra oxygen through a tube and into the nose). On 04/01/25 at 11:28 AM, a follow-up observation of R77's nebulizer and O2 tubing was made. Observed orange labels that were not on the O2 tubing and nebulizer tubing when an observation was made on 03/31/25. The O2 concentrator was on, and the flow rate was 2.5 liters per minute (LPM) and R77 was observed to have the nasal cannula not in use. The orange labels had instructions to change the tubing on Saturday and included a back date of Saturday, 03/28/25. R77 stated a staff member changed the tubing and added the labels yesterday, 03/31/25. Review of R77's physician orders confirmed R77 was admitted with O2, Supplemental Oxygen as needed for SOB [shortness of breath] Titrate to keep SP02>90% [oxygen saturation], the order did not include the oxygen flow rate, specify for what duration, and delivery method. On 03/13/24, continuous O2 at bedtime was ordered .every evening and night shift for patient needs O2 to sleep, the order did not specify the oxygen flow rate, specify for what duration, and delivery method. On 03/28/25, albuterol sulfate inhalation nebulization solution 2.5 milligrams (mg.) /3 milliliters (ml.) 0.083% (Albuterol Sulfate) . 3ml inhale orally via nebulizer four times a day for SOB was ordered but started on 03/29/25. On 04/02/25 at 02:06 PM, an interview and concurrent record review with MDS Director (MDSD) 67 and MDSD43 were done. The MDSD67 confirmed R77's admission MDS assessment did not include O2 therapy, it was not care planned, and the physician orders did not include all the requirements for a O2 therapy order. MDSD43 reported the orders should have the oxygen flow rate, for example 2LPM and deliver method, such as, nasal cannula or face mask. Review of R77's Medication Administration Record (MAR) for the month of March 2025, documented R77 was administered O2 during the evening and night shift daily. The as needed supplemental O2 was not administered during the month of March. On 04/02/25 at 04:07 PM, an interview with Director of Nursing (DON) was done. Inquired what time nursing staff are to administer R77's O2 for bedtime, DON reported when she is sleeping and confirmed the order did not specify the duration. This surveyor described the two observations of the O2 concentrator on while R77 was awake, and DON confirmed it should have been turned off or documented in the MAR that supplemental O2 was administered. DON further confirmed R77's nebulizer tubing and O2 tubing should be labeled and the O2 tubing should be changed once a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, interviews, and record reviews, the facility failed to ensure that one of two residents (Resident (R) 390) sampled for dialysis, was provided with professional standards of practice. The facility failed to remove R390's pressure dressing after two hours from the completion of R390's Hemodialysis (HD) treatment. This deficient practice puts residents on dialysis at risk for access clotting and complications. Findings include: Cross reference to F656, Development of Comprehensive Care Plans. On 04/02/25 at 09:00 AM, observed R390 with right upper arm fistula pressure dressing still on from yesterday's HD treatment. R390 stated that staff will take it off when they have time and do not really check for the thrill and bruit (a thrill is a palpable sensation felt over the fistula and bruit is a swooshing sound heard with a stethoscope which indicates good blood flow and fistula function). R390 stated he will usually be the one that takes it off. R390 stated he came back from dialysis yesterday at 04:30 PM. On 04/02/25 at 9:30 AM, record review of R390's care plan noted, HD focus that was initiated on 03/20/25, interventions included to monitor, document, and report as needed any signs and symptoms of infection to access site redness, swelling, warmth or drainage, but did not include any interventions to assess for thrill and bruit in care plan. Treatment Administration Records (TAR) showed the dialysis fistula checks for thrill and bruit check were being done every shift. On 04/02/25 at 09:05 AM, interview with Registered Nurse (RN) 30 completed. RN30 stated they remove the dressing when R390 comes back after dialysis. RN30 stated, We follow the orders and observe the access site for any signs and symptoms of redness, bleeding, and for the thrill/bruit. RN30 also noted the last assessment was done last night at 12:10 AM, and that he has not done his assessment yet this morning. RN30 was asked by surveyor to accompany surveyor to R390's room to confirm that R390's dressing was still on. When asked, why the dressing was still on, RN30 replied, I'm not sure, I will have to check our facility's policy. On 04/02/25 at 10:00 AM, interview with Director of Nursing (DON) confirmed that they should be checking for the thrill and bruit before and after dialysis and every shift. DON also stated that they should be removing the dressing but was not sure how soon after dialysis they must remove it. On 04/02/25 at 12:00 PM, observed R390's right arm fistula without pressure dressing. On 04/02/25 at 03:02 PM, interview with a dialysis charge nurse (DCN) from a dialysis facility was completed. DCN confirmed that the recommendations to remove the fistula pressure dressing is two hours after dialysis treatment. When asked why after two hours, DCN replied, This is to prevent clotting. If left too long, it will most likely end up clotting the access. On 04/02/25, record review of the facility's policy on Quality of Care, Dialysis, with revised date of 04/2018, it stated that the facility will provide residents, who require, dialysis, care and service consistent with professional standards of practice in the Guidelines section of the policy, it also states, 13. Facility will monitor and document the status of the resident's access site upon return from the dialysis treatment center to observe for bleeding or other complications. The facility did not meet this guideline as evident by pressure dressing not removed after two hours from R390's return from dialysis treatment.

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	125020	A. Building B. Wing	04/03/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews and record review the facility failed to ensure sufficient nursing staff were available to provide restorative services for one of three residents (Resident (R) 29) sampled for limited range of motion (ROM). As a result, R29 did not receive consistent restorative nurse aide treatment and services to maintain and/or prevent a decline in ROM. This deficient practice puts 30 residents in the RNA program at risk for a decline in ROM. Findings include: Cross reference to F688, Increase/Prevent Decrease in ROM/Mobility. The facility failed to provide consistent application of splint and ROM exercises for R29. On 04/03/25 at 08:31 AM, observed R29 eating breakfast with assistance from Certified Nurse Aide (CNA) 75, in bed her left arm was folded with fisted hand on chest and no splint. Inquired with CNA75 if R29 has a splint for her hand and knee, CNA75 reported R29 should be wearing her splint daily but the facility did not have an RNA today. CNA75 proceeded to explain that she could put the splint on. Inquired with R29 in her native language, Korean, if the facility had been helping her with her exercises and stretches, she stated no and that she would like to continue her exercises and stretches. On 04/03/25 at 08:37 AM, interview with MDS Director (MDSD) 67 was done. MDSD67 confirmed she oversaw the RNA program and R29 gets services daily. RNA reported that R29's services should continue even under transmission based precautions (TBP) and that she may not be getting services due to RNA staff called to floor as CNA. MDSD67 explained that there are limited number of staff that are trained to provide RNA services. If RNA staff are working as a CNA they are not able to see everyone or are too busy with their CNA duties to provide RNA services. Review of the list of staff able to provide RNA services are a total of five staff, two assigned RNA staff and three CNAs that can cover. On 04/03/25 at 08:53 AM, an interview and concurrent record review with Nursing Scheduler (NS) was done. NS confirmed there was no RNA staff today, 04/03/25. NS reported that the facility is supposed to have two RNA staff but most days they only have one available. For CNA, there are usually 11-12 CNAs on the floor depending on the census with a maximum of 9-10 residents per CNA. Concurrent review of the day shift Nursing Assignment from 03/26/25 to 04/03/25 document one RNA staff from 03/26/25 to 04/02/25 and no RNA staff on 04/03/25. NS was not able to fill the RNA positions due to the availability of CNAs those days (CNA staff calling in sick). One of the two regular RNA staff were on vacation during the sampled timeframe. On 04/03/25 at 09:59 AM, an interview with CNA39 was done. CNA39 stated she was trained to provide RNA services but has not provided RNA services in a long time. Inquired if CNA39 would be able to provide RNA services when assigned as a CNA, CNA39 reported she would not have the time to do both and stated resident needs would get neglected due to the amount of time spent in providing RNA services. On 04/03/25 at 10:54 AM, an interview with CNA75 was done. CNA75 stated she was trained to provide RNA services and has not provided RNA services in a long time due to needing CNAs on the floor. Inquired if CNA75 would be able to provide RNA services when assigned as a CNA, CNA75 stated it would be too much. (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/25 at 11:26 AM, an interview with Director of Nursing (DON) was done. DON reported if there is not enough CNAs on the floor they would need to ask the RNAs to work as CNAs and there would be no coverage for RNA.

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	125020	A. Building B. Wing	04/03/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement a thorough process in narcotic log documentation and reconciliation for two of four medication carts observed. This deficient practice hinders the process necessary to promptly identify loss or potential diversion of the controlled medications used to meet the needs of the residents. In addition, the facility failed to implement a process that assures the accurate and timely disposition of discontinued and/or expired medications. This deficient practice hinders the promotion of safe administration practices that decrease the risk for medication errors. These deficient practices have the potential to affect all residents in the facility who take medications. Findings include: 1) On 04/02/25 at 09:33 AM, an inspection of medication cart 1C was done with Registered Nurse (RN) 56. Observed a blister pack card of Oxycodone (a narcotic) IR 5 milligrams (mg) with 22 pills remaining for Resident (R) 236. Review of the Controlled Drug Record noted that there should have been 24 pills remaining. Concurrent interview with RN56 revealed that she had administered one pill to R236 at 09:18 AM but had neglected to sign it out on the Controlled Drug Record. RN56 also stated that she had dropped a tablet and wasted it but had neglected to sign that wasted tablet out of the inventory count on the Controlled Drug Record. When asked what the normal process was to sign off/document narcotics, RN56 answered that narcotics are signed off on the Controlled Drug Record after they administer it because they [the resident] might refuse it. On 04/02/25 at 10:00 AM, an interview was done with Director of Nursing (DON) in the Training Room. When asked about narcotic administration and documentation, DON stated that narcotics should be signed out on the Controlled Drug Record upon preparation of the medication, when they pop it, prepare it. DON confirmed staff should not be signing narcotics out after administration, agreeing that if a resident refuses a narcotic that is signed out, then the medication is wasted and documented on the Controlled Drug Record as refused. Review of the Controlled Substances policy and procedure, last updated 11/17, revealed the following: 4. When a controlled medication is administered, the licensed nurse . immediately enters the following information on the accountability record when removing dose from controlled storage . Date and time of administration . Amount administered . 5. Administer the controlled medication and document dose administration on the MAR [medication administration record]. 2) On 04/02/25 at 09:06 AM, an inspection of medication cart 2B was done with RN28. Observed a 100-count box of Ferrous Gluconate 324 mg with an expiration date of 3/25 that was more than half-filled. Also observed a 30-count blister pack card of Methocarbamol for R67. Concurrent interview with RN28 confirmed that the Ferrous Gluconate was expired, and that R67 had been discharged from the facility. On 04/02/25 at 09:18 AM, an interview was done with RN65 (who also served as 1 of 2 Assistant (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Directors of Nursing) at Nurses' Station 2. RN65 confirmed that the expired Ferrous Gluconate should have been removed from the medication cart and disposed of. Regarding the Methocarbamol, RN65 confirmed that R67 had been discharged from the facility to home on [DATE] and stated that usually all medications are sent home with residents upon discharge. Concurrent record review noted that the Methocarbamol had been discontinued on 02/28/25. RN65 confirmed the medication should have been pulled from the medication cart at that time and placed in the medication room for disposal.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, the facility failed to document the rationale for not making any changes to the pharmacist's recommendations during a monthly medication regimen review (MRR) for one of five residents (Resident (R) 285) sampled for unnecessary medications. This puts R285 at risk for complications due to medications administered. Findings include: Review of R285's Interim Medication Regimen Review dated 03/13/25, the pharmacist documented the following action required and high-risk medication monitoring recommendations; Aspirin EC .Do not crush, On Antiplatelet: Aspirin, Clopidogrel .Monitor for s/s [signs and symptoms] of bleeding bruising; monitor for thromboembolism. On Diabetic agent: Degludec, R Insulin .Monitor for s/s of hypoglycemia; monitor for s/s hyperglycemia and On Opioid agent: Oxycodone .Monitor for constipation; monitor for s/s delirium/ over sedation/ change in mental status and reduced respirations. The facility documented they accepted the recommendation for do not crush aspirin and signed the MRR on 03/13/25. Review of R285's physician orders, the facility did not make changes to R285's aspirin to include in the order do not crush and did not include the high-risk medication monitoring recommendations for use of diabetes and opioid medications. On 04/02/25 at 03:53 PM, an interview with Director of Nursing (DON) was done. DON stated they did not make changes to the orders or add the monitoring to the orders because it is the facility's standard of practice not to crush aspirin unless it is a chewable tablet and to monitor for the s/s hypoglycemia and hyperglycemia of diabetic medications and s/s of constipation for opioid medications and the facility does not document the monitoring. During the interview reviewed, another resident (R77) for constipation and opioid use. The review found nursing staff were not monitoring this resident for constipation related to use of opioid medication. (Cross reference to F684).

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	125020	A. Building B. Wing	04/03/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, as evidenced by two medication errors observed out of 28 opportunities for errors, for an error rate of 7%. Safe and timely medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, Resident (R) 56 was placed at risk of negative outcomes due to medication errors. This deficient practice has the potential to affect all residents in the facility taking medications administered by staff. Findings include: On 04/01/25 at 08:30 AM, began observing Registered Nurse (RN)14 as he prepared and administered medications to a resident in room [ROOM NUMBER]. RN14 was observed completing medication preparation, entering room [ROOM NUMBER], and returning to the medication cart without entering any other rooms. RN14 was also not observed with a blood pressure monitor. On 04/01/25 at 08:40 AM began observation of RN14 preparing and administering medications to Resident (R)56 in room [ROOM NUMBER]. Observed RN14 prepare (amongst other medications) the following: Senna-Plus (a stool softener and stimulant laxative combination), two (2) tablets. Amlodipine (used to treat high blood pressure and chest pain) 5 milligrams (mg), one (1) tablet, with instructions to hold the medication if resident's systolic blood pressure (the force of the blood flow when blood is pumped out of the heart) is less than 100. Review of the Medication Administration Record (MAR) noted that a blood pressure of 113/77 had been entered at 06:10 AM by Certified Nurse Aide (CNA) 71. Lisinopril (used to treat high blood pressure) 5 mg, one (1) tablet, with instructions to hold the medication if resident's systolic blood pressure is less than 120. Review of the MAR noted that a blood pressure of 122/77 had been entered at 08:46 AM by RN14. Clearlax 17 grams (gm) of powder mixed in approximately 8 ounces of water. At 08:47 AM, observed RN14 enter R56's room and hand her a small plastic cup of medications, stating he had her aspirin, blood pressure medications and Senna-Plus. RN14 then handed R56 the cup of water mixed with Clearlax and stated, I also have some water for you. R56 immediately refused the Senna-Plus. RN14 excused himself to grab gloves so he could remove the two Senna-Plus tablets from the cup. While he was gone, the State Agency (SA) asked R56 why she did not want to take the Senna-Plus. R56 responded that it makes me dizzy, and I want to control my functions (motioning to her lower abdomen). After R56 swallowed the remaining pills with a small sip of the water with Clearlax, RN14 left the room. At 08:50 AM, an interview was done with RN14 outside of R56's room. Asked RN14 if he knew why R56 had refused the Senna-Plus. He stated, she doesn't like to take a laxative. Asked RN14 if R56 knew there was a laxative in the 'water' he gave her since he did not mention it. RN14 answered that R56 knows there is laxative in the water, admitted he did not say it, but should have. Stated R56 frequently refuses the Senna-Plus but takes the Clearlax. (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 08:53 AM, interviewed R56 in her room. When asked if she was aware that there was a laxative mixed into the water R14 had given her (which still had more than half a cup remaining). R56 answered no, and asked SA does it affect my digestion? SA informed her that it is used to treat constipation and will cause her to poop. R56 stated she wanted to refuse it. SA informed RN14 that R56 wanted to refuse the remaining Clearlax and asked if it is his normal process to leave the room before all medications have been consumed. RN14 confirmed that he should not have left the room until all medications were consumed. While reconciling the other medications during record review, noted the discrepancy of two different blood pressures documented for R56 for high blood pressure medications (with two different parameters) given at the same time. On 04/01/25 at 10:00 AM, when R56 was asked if RN14 had taken her blood pressure at any time that morning, R56 answered no. At 10:05 AM, an interview was done with RN14 at Nurses' Station 2. When asked about the discrepancy in blood pressures documented on the MAR for medications given at the same time, RN14 stated he took R56's blood pressure at around 08:30 AM, did not write it down, but remembered the reading at 08:46 AM when he documented the blood pressure as he was preparing the Lisinopril. RN14 stated he took the blood pressure himself because there was no blood pressure available in the electronic health record (EHR) that morning. SA informed RN14 that a measurement of 113/77 was in the EHR, and he used it to document the blood pressure when he prepared R56's Amlodipine, which he did shortly before he prepared her Lisinopril. Asked RN14 about R56's cognition. He stated that R56 was alert and oriented times four [fully alert and oriented to person, place, time, and event]. Informed RN14 that SA had observed him from 08:30 AM and made no observation of him taking any residents' blood pressure or entering R56's room. In addition, R56 stated she did not remember RN14 taking her blood pressure that morning. RN14 could not explain why there was no evidence to validate that he had taken R56's blood pressure that morning. On 04/02/25 at 11:57 AM, an interview was done with Director of Nursing (DON) outside the Administrator's office. DON confirmed the expectation is that when taking a blood pressure, it is either written down or put into the EHR immediately. DON also confirmed that all medication should be consumed before walking away from the resident, not left at the bedside, and that RN14 should have informed R56 there was a laxative in her water, especially if she refused laxative pills. Review of R56's MAR for March 2025 noted that R56's blood pressure was too low to meet the parameter for Lisinopril administration 43 out of 62 opportunities, or 69% of the time. This reflects the importance of ensuring her blood pressure is taken and accurate prior to administration.

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	125020	A. Building B. Wing	04/03/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure all medications used in the facility were stored in accordance with professional standards for one of four medication carts observed. Proper storage of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications. Findings Include: On 04/01/25 at 08:22 AM, observed an unlocked medication cart left outside of a resident's room with no staff in sight. At this time the Infection Prevention Registered Nurse (RN) 94 was seen near by and inquired of RN94 if the medication cart is to be locked by the nurse before leaving it and she confirmed it is supposed to be locked. At 08:23 AM, RN85 returned to the medication cart. Inquired of RN85 if she was educated to lock her medication cart before she passes medication and she confirmed she had and acknowledged the medication cart was supposed to be locked before leaving it.

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	125020	A. Building B. Wing	04/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections were implemented. This is evidenced by the facility failing to ensure staff followed transmission-based precautions (additional measures used to help stop infection transmission when a patient/resident has been found to be infected or colonized with certain infectious agents) by wearing the proper personal protective equipment (PPE), followed standard precautions (the basic level of practices used to prevent the spread of infection) by performing hand hygiene, and had PPE and PPE disposal receptacles readily available both inside and/or outside the rooms. These deficient practices have the potential to affect all residents in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: 1) On 03/31/25 at 10:28 AM, Certified Nurse Aide (CNA) 48 was observed coming out of R78's room wearing only a surgical mask. R78 is in quarantine because she tested positive for COVID. Inquired of CNA48 if she is supposed to wear other personal protective equipment (PPE) such as a shield, N95, gown and gloves when going into R78's room. CNA48 stated no that she was delivering diapers. On 03/31/25 at 10:30 AM, an interview was conducted with Registered Nurse (RN) 93. Inquired if staff are expected to use gown, gloves, N95 and face shield when going into resident's room who has COVID. RN93 stated staff are expected to use PPEs mentioned when going into a room where a resident is positive for COVID. Shared observation and asked if this was okay as CNA stated she was delivering diapers and RN93 confirmed it was not, staff are expected to use PPEs. 2) On 03/31/25 at 12:50 PM, observed R89 resting/sleeping in her bed. Inquired of Registered Nurse (RN) 21 if R89 was going to eat her lunch (covered lunch tray was on her bedside table). RN21 stated she would get another staff to assist her to move resident up in her bed so that she can help her with her meal. Resident woke up at brief intervals. Two RNs, RN21 and RN65, put on PPEs (gown, gloves and mask) as R89 had enhanced barrier precautions (EBP). Resident was moved up in her bed by RN21 and RN65 using her draw sheet. Resident's head of bed was raised and resident was positioned comfortably as staff spoke to her. RN21 moved resident's personal items from the bed side table to her small dresser top near her bed. RN21 moved two pillows from her bed onto a metal chair near R89's bed. RN21 then started to feed resident. R89 took one very small amount of mashed potatoes with gravy. R89 did not appear to want to eat any more but did want to drink some milk when it was offered by RN21. RN21 opened the milk container and noticed she did not have a straw available for resident to use. RN21 took off her gloves, went to the door and requested a straw from staff in the hallway. At this time, RN21 also got a new pair of clean gloves. RN21 threw away the dirty gloves and put on the clean gloves, RN21 did not perform hand hygiene. At this time surveyor shared observation with RN21 and asked if she should have done anything after taking off her dirty gloves and she stated, I thought my hands were clean. RN21 also did not identify need to change gloves after positioning resident prior to assisting her with her meal. Review of facility's policy titled Infection Prevention and Control Program (IPCP) revised on 06/08/22 states Purpose The facility will establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection. Standard Precautions . 2. Staff will perform hand hygiene, even if gloves are used: a. Before and after contact with the resident: . d. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125020	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Honolulu, LLC	1930 Kamehameha IV Rd Honolulu, HI 96819

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	After removing PPE;. 3) On 04/01/25 at 08:16 AM, observed CNA16 wearing full PPEs of face shield, N95, gown and gloves who had brought out a breakfast tray from a quarantined room with a resident who was positive for COVID. CNA16 returned R78's breakfast tray to the cart before doffing PPEs. Inquired if residents with COVID have paper products instead of a tray. CNA shared the tray on the cart was from the resident who has positive for COVID. 4) On 04/02/25 at 09:05 AM, went to R39's room to observe if resident's call light was within his reach. Resident was observed sleeping in his bed and call light was observed on the ground. Inquired with RN94 if call light should be near resident. RN94 confirmed the call light is to be left with the resident before staff leave the room. RN94 picked up the call light and put it on the resident's bed. RN94 did not clean the call light before putting it on the resident's bed. 5) On 04/02/25 at 09:27 AM, R18 was observed sitting in the hallway outside of her room in her wheelchair. R18 has an indwelling urinary catheter that had a privacy bag hanging from the wheelchair that was resting on the ground. On 04/02/25 at 09:30 AM, interviewed Director of Nursing (DON) who was walking in the hallway near R18. Inquired of DON if R18's privacy bag for her indwelling urinary catheter bag should be resting on the ground and she said No and I will get a new one. On 04/02/25 at 01:13 PM, interviewed facility Infection Preventionist (IP) nurse in the Director of Nursing's office. Inquired regarding PPEs use for residents with COVID versus EBP for doffing PPEs and she stated there is no difference. Inquired about placement of trash cans outside of COVID positive patient's bedroom door and IP nurse stated there is no room in the resident's room for the trash can and that is why it is kept in the hallway. Inquired about staff coming out of resident's room who is on Contact Precautions and there is no rubbish can for used PPEs, surveyor shared an observation with IP that another surveyor had of staff who walked across the hallway and took off their PPEs and threw it away in the rubbish can. IP stated staff are not to do this they are to take off PPEs and dispose of it in the trash can that is right outside the room or dispose of inside the room. On 04/ 03/25 at 10:10 AM, observed facility had posted instructions from the Centers for Disease Control and Prevention (CDC) Use personal protective equipment (PPE) when caring for patients with confirmed or suspected COVID-19 dated 06/03/20 which stated Doffing (taking off the gear): More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing. 1. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak). 2. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful (continued on next page)

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	125020	A. Building B. Wing	04/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. * 3. HCP may now exit patient room . 7) On 03/31/25 at 12:28 PM, observed CNA78 delivering R86's lunch tray to her. It was noted at this time by the transmission-based precautions (TBP) signage outside the door, that R86 was on Contact Precautions (precautions intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment). Review of the TBP signage outside the door noted that gloves and a gown should be donned (put on) prior to entering the room. Observation of CNA78 noted that she was not wearing gloves or a gown as she delivered R86's lunch tray, pressed up against R86's bed as she cut R86's food, and set up her lunch for her. Interview was done with CNA78 at 12:33 PM outside R86's room. When asked about R86's TBP, CNA78 stated that she was told by nurses earlier that morning that she did not need to wear any PPE unless she was touching the resident. CNA78 could not verbalize the difference between Contact Precautions (TBP) and Enhanced-Barrier Precautions (protective precautions but not TBP), or when each would be used. 8) On 03/31/25 at 12:42 PM, observed signage outside of room [ROOM NUMBER] indicating that both residents in the room were on Enhanced-Barrier Precautions requiring staff to don PPE if in direct contact with residents. Also noted that resident in 105B was on Contact Precautions. Made observations at this time that neither room had a trash receptacle for used/dirty PPE disposal either directly inside or directly outside the rooms. Observed CNA78 exit room [ROOM NUMBER], cross the hallway with her dirty gown on, stop at the trash receptacle outside the room across the hall, doff (take off) her used PPE, and throw it away. On 04/02/25 at 08:45 AM, made observation outside room [ROOM NUMBER] that staff were exiting the room to grab clean gloves from the top drawer of the PPE cart outside the room. Also observed that not every room had a PPE cart outside of it. Concurrent interview was done with CNA92 outside room [ROOM NUMBER]. When asked about the availability of gloves, CNA92 stated that gloves are available in the rooms but only in the bathroom, and if there is a PPE cart outside the room, gloves are available inside the top drawer as well. CNA92 agreed that if there is no PPE cart outside the room, and a resident is in (or blocking) the bathroom, it can be difficult to access a clean pair of gloves. 6) On 03/31/25 at 11:45 AM, observed R387 with indwelling catheter, secured to his right leg, draining yellow urine, partially covered with a dignity bag and resting on the floor without a barrier. On 03/31/25 at 12:00 PM, interviewed CNA45, and showed her the catheter on the floor. CNA45 confirmed that catheter should not be on the floor, and it was also full and needed to be emptied. On 04/02/25 at 11:00 AM, interview with DON confirmed that catheter care included the catheter not being on the ground for risk of infection.