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	06/04/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, record reviews, the facility failed to ensure the resident's right to a dignified existence for 1 of 2 residents (Resident) (R) 124) sampled for dignity. As a result of this deficiency, the resident was not promoted the right to the maintenance or enhancement of the resident's quality of life. Findings include:On 06/01/26 at 12:23 PM, concurrent interview and observation were done with R124. Observed R124 self-propelling himself to the dining area from Physical Therapy activities. Observed urinary drainage bag hanging under the wheelchair, with a privacy/dignity bag covering about a third of the drainage bag. When R124 was asked about why urinary drainage bag was not fully covered, R124 stated that he was also concerned about it, and R124 also stated that drainage bag should always be covered. R124 proceeded to reach for the urinary bag under wheelchair and adjusted privacy bag to cover urinary drainage bag but was unable to resolve issue. On 06/03/26 at 12:53 PM, concurrent observation and interview were done with R124 in the dining room. Observed R124 with a urinary leg bag securely attached to right leg. R124 mentioned that RN11 changed urinary bag to a leg bag and resident was also instructed that urinary bag needs to be changed to leg bag every time R124 leaves the room. R124 stated that he was concerned abouty his privacy since resident prefers to use short pants and stated, I do not feel comfortable using the leg bag since it does not have any privacy bag covering it. R124 also explained that leg bag is always exposed to other people around him when R124 is outside room. On 06/03/26 at 01:13 PM, interview was done with RN11. Asked RN11 if urinary bag should have privacy bag that can cover the entire bag to provide privacy for the resident, RN11 agreed that all urinary bags should always be fully covered with privacy bags. On 06/04/26 at 10:02 AM, interview was conducted with Director of Nursing (DON). Asked DON if urinary bags should have privacy bags to provide privacy for the resident, DON confirmed that all urinary bags should always be fully covered with privacy or dignity bags. DON also explained that the facility is in the process of ordering new sets of urinary leg bags that comes with dignity or privacy bags to provide privacy for the residents. Review of facility policy titled Resident Rights, Respect and Dignity with a revision date of 09/20/22 stated, .1. The resident has a right to be treated with respect and dignity.

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
	125020	A. Building B. Wing	06/04/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation and interview, the facility failed to ensure appropriate treatment/care of the catheter to prevent urinary tract infection for 1 of 2 residents (Resident (R) 144) sampled. As a result of this deficient practice, residents are at risk of a urinary tract infection. Findings include: On 06/03/26 at 08:29 AM, observed Resident (R) R144 seated in a wheelchair in the entrance of the resident's assigned room. R144's catheter bag was out of the privacy bag (approximately the bottom third of the catheter bag bag) and was resting directly on the floor, along with the tubing. R144 moved the wheelchair and ran over the exposed catheter bag. Alerted Registered Nurse (RN) 15 of the situation. RN15 secured the catheter bag and tubing off the floor. Inquired with RN15 if it was okay for the catheter bag and tubing to be in direct contact with the floor. RN15 confirmed appropriate treatment/care of the catheter bag and tubing was to ensure it was not in direct contact with the floor.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to provide a safe and sanitary environment as evidenced by a pill cutter with white and brown sediments, located in 1 of 3 medication carts checked. This deficient practice could potentially put residents at risk of contamination that receive medication(s) being cut by this equipment.Findings include:On 06/03/26 at 08:10 AM, the facility's station 1C medication cart was checked and a pill cutter, located in the top drawer of the medication cart, was observed to have large amounts of white/brown sediments in the interior portion of the cutter. The Registered Nurse (RN) 6 administering medications from this cart was concurrently interviewed. RN6 confirmed seeing the white and brown sediments in the pill cutter and stated it was from not cleaning it. RN6 also stated that the cutter should be cleaned after each use.