

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THE ARC IN HAWAII - EWA C	STREET ADDRESS, CITY, STATE, ZIP CODE 91-824 C HANAKAHI STREET EWA BEACH, HI 96706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 091	<p>11-99-9(d)(2)(A) DIETETIC SERVICES</p> <p>All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to maintain stored foods in a sanitary manner to prevent food borne illnesses.</p>	9 091	<p>11-99-9(d)(2)(A) DIETETIC SERVICES</p> <p>All expired and unrefrigerated open food items were immediately disposed of.</p> <p>All home staff were retrained on infection control including reading manufacturers expiration dates and labels regarding refrigeration needs at training on 11/17/15.</p> <p>At home managers meeting on 10/28/15 Director of Nursing and ICF Program Manager discussed with all Home Managers that they need to check manufacturers' expiration dates and label food accordingly as well as reading all labels regarding refrigeration needs or suggested number of days to use within after opening.</p> <p>From this point forward all outside food purchased by family members or guardians will be double checked for manufacturer's expiration dates and labeled accordingly.</p> <p>Home Manager to monitor food storage for unrefrigerated items. Home Managers to check dates of food storage items every 6 months.</p>	<p>11/17/15</p> <p>10/28/15</p> <p>on-going</p> <p>on-going</p> <p>bi-annually</p>
9 108	<p>11-99-11(c)(1) RESIDENT DAILY LIVING CARE AND TRAINING</p> <p>The facility staff shall provide at</p>	9 108		

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PR	SIGNATURE	TITLE Exec. Director	(X6) DATE 12/3/15
--	-----------	-------------------------	----------------------

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER
THE ARC IN HAWAII - EWA C

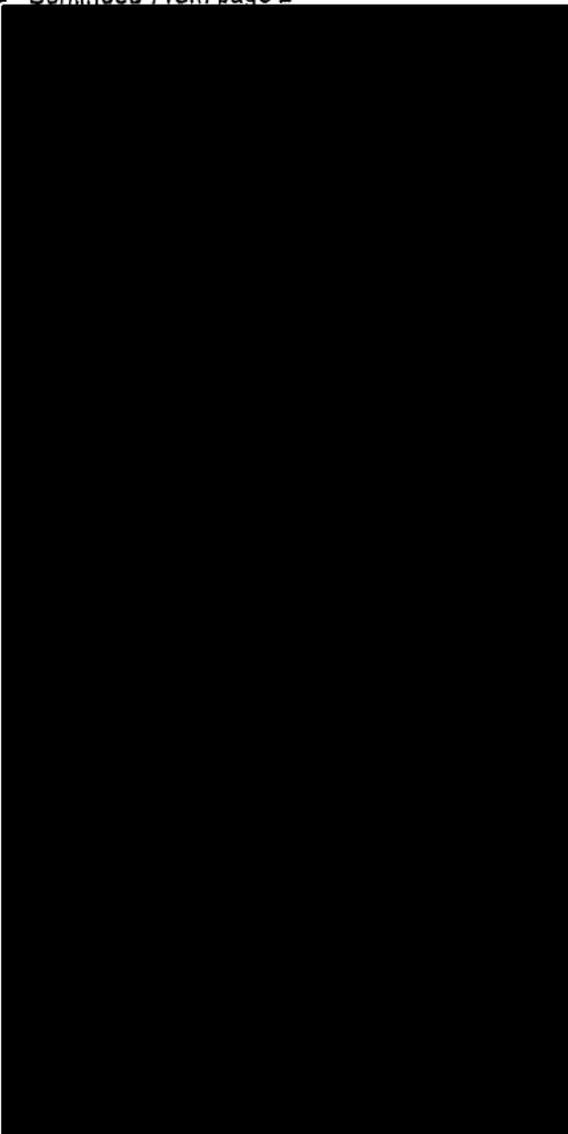
STREET ADDRESS, CITY, STATE, ZIP CODE
**91-824 C HANAKAHI STREET
EWA BEACH, HI 96706**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 108	<p>Continued From page 1</p> <p>least the following:</p> <p>Supportive services to enable residents to participate fully in appropriate daily activities. This Statute is not met as evidenced by: Based on clinical record review, observations and staff interviews, the facility failed to ensure 1 of 3 clients in the active case sample received a continuous active treatment program.</p>	9 108	<p>11-99-11(c)(1) RESIDENT DAILY LIVING CARE AND TRAINING</p> <p>Home Manager spoke to [redacted] regarding the need to sit at eye level during meals and that participants should not have to ask more than once for help with feeding. 10/23/15</p> <p>RN revised [redacted] Swallow and Feeding guidelines 11/13/15</p> <p>[redacted]</p> <p>All home staff were retrained on [redacted] Swallow and Feeding guidelines at training held on 11/17/15. 11/17/15</p> <p>At Home Managers meeting on 10/28/15, Director of Nursing discussed and handed out a memo for all home staff to read and sign. The memo states that staff must sit at eye level with participants during meals and feeding and that staff must follow participants specific feeding/swallow guidelines. 10/28/15</p> <p>RNs will review all feeding protocols and if necessary will include how many times a participant should attempt to feed themselves before staff will offer assistance with feeding and whether or not staff should ask a participant before each meal if they need assistance with feeding. 12/11/15</p>	

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	---	--

NAME OF PROVIDER OR SUPPLIER THE ARC IN HAWAII - EWA C	STREET ADDRESS, CITY, STATE, ZIP CODE 91-824 C HANAKAHI STREET EWA BEACH, HI 96706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 108	Continued From page 2 	9 108	11-99-11(c)(1) RESIDENT DAILY LIVING CARE AND TRAINING Continued Both HMs and Instructors will monitor during meals. CM and RN to follow up with HMs and Instructors at monthly meetings. CM and RN to monitor quarterly.	on-going Monthly Quarterly

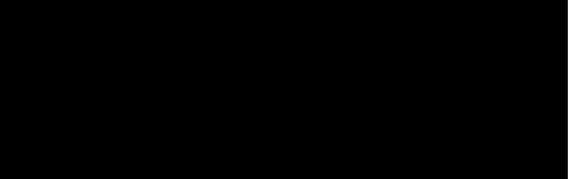
Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER

THE ARC IN HAWAII - EWA C

STREET ADDRESS, CITY, STATE, ZIP CODE
91-824 C HANAKAHI STREET
EWA BEACH, HI 96706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 108	Continued From page 3 	9 108		
9 148	11-99-14(g) HOUSEKEEPING All areas which have contained infectious residents and materials shall be thoroughly cleaned by appropriate sanitizing methods. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure that a commode chair was sanitized.	9 148	11-99-14(g) HOUSEKEEPING  cleaned and sanitized the shower commode on 10/22/15. All home staff were retrained on infection control including disinfecting the shower chair after each use at training held at the Ewa C home on 11/17/15.	11/17/15
	Findings include: 		Director of Nursing and ICF Program Manager discussed with all Home Managers at the Home Managers meeting on 10/28/15 that all shower chairs and commodes must be disinfected after each use. HM to monitor when commode used. CM and RN to follow up with HM at monthly meetings. CM and RN to monitor quarterly.	10/28/15 on-going Monthly Quarterly
9 151	11-99-15(b) INFECTION CONTROL	9 151		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	---	--

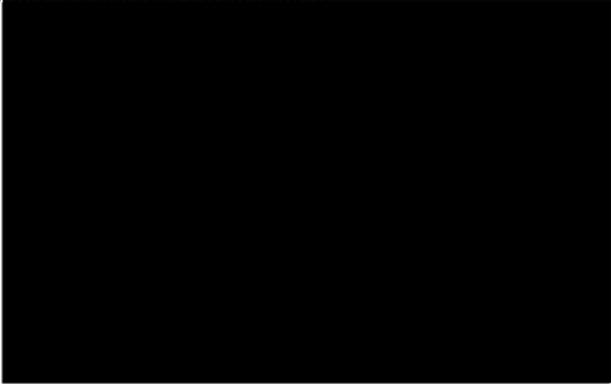
NAME OF PROVIDER OR SUPPLIER THE ARC IN HAWAII - EWA C	STREET ADDRESS, CITY, STATE, ZIP CODE 91-824 C HANAKAHI STREET EWA BEACH, HI 96706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 151	<p>Continued From page 4</p> <p>There shall be appropriate policies and procedures written and implemented for the prevention and control of infections and the isolation of infectious residents.</p> <p>This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that proper infection control techniques are consistently implemented.</p> <p>Findings include:</p> <div style="background-color: black; width: 100%; height: 100%; min-height: 300px;"></div>	9 151	<p>11-99-15(b) INFECTION CONTROL</p> <p>Home Manager spoke to [REDACTED] immediately following the incident on the evening of 10/20/15, regarding the need to wear gloves when administering blood glucose testing or handling any bodily fluids.</p> <p>All home staff were retrained on proper glove usage and infection control procedures at training on 11/17/15.</p> <p>At a recent Home Managers meeting on 10/28/15, the Director of Nursing discussed and handed out a memo for all home staff to read and sign. The memo states that gloves should be worn during blood sugar tests.</p> <p>Home Manager to monitor during blood sugar testing. on-going RN to follow up with HM at monthly meetings. Monthly RN to monitor quarterly. Quarterly</p>	<p>11/17/15</p> <p>10/28/15</p>

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	--	--

NAME OF PROVIDER OR SUPPLIER THE ARC IN HAWAII - EWA C	STREET ADDRESS, CITY, STATE, ZIP CODE 91-824 C HANAKAHI STREET EWA BEACH, HI 96706
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
9 151 - Continued From page 5		9 151	This page intentionally left blank.	