STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G036	A. BUILDING: _____	
		B. WING _____ RECEIVED	12/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC OF MAUI - HALE KIHEI	179 HALE KAI STREET KIHEI, HI 96753

2016 JAN -7 P 12: 24

(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
9 000	**INITIAL COMMENTS** A re-licensing survey was conducted by the State Agency on 12/9/15 thru 12/11/15. The census upon entrance included 4 clients.	9 000		
9 179	**11-99-20(c)(5) NURSING SERVICES** In facilities with residents requiring nursing services, the following additional care shall be provided: Regular documentation in the resident record of all services rendered. This Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to follow up on the needs for 1 of 4 residents. Findings include:	9 179	**Reference Tag ID 9 179** **11-99-20 (c)(5) NURSING SERVICES** **The facility failed to follow up on the needs of 1 resident.** To correct this issue, the following actions were taken: 1) The resident was brought to Maui Medical Group ████████ ████████████████ 2) The agency RN gave a verbal order for a one-time dose of ████ ████████████████ The agency RN was retrained to request a physician's authorization for any desired changes to a physician's PRN order. 3) Staff was retrained to follow RN instructions and notify the RN whenever a PRN medication is ineffective in accordance with agency policy. The RN will ensure written instructions are available for staff or ensure verbal instructions are transcribed onto the	1/5/16

fice of Health Care Assurance

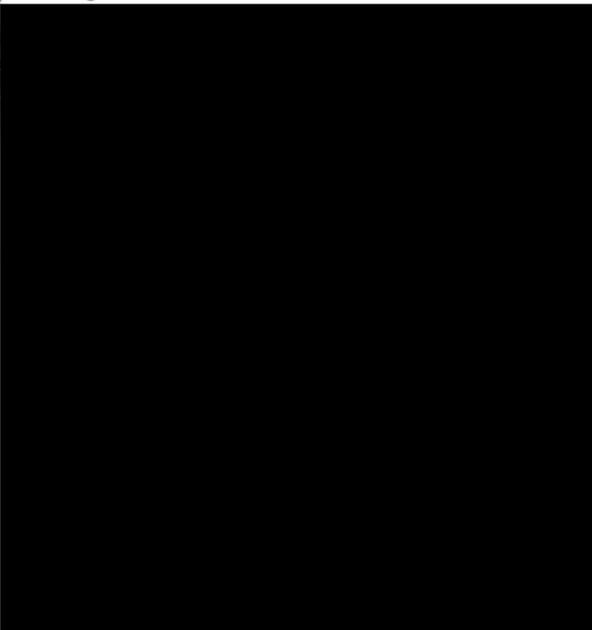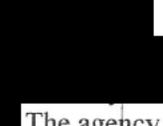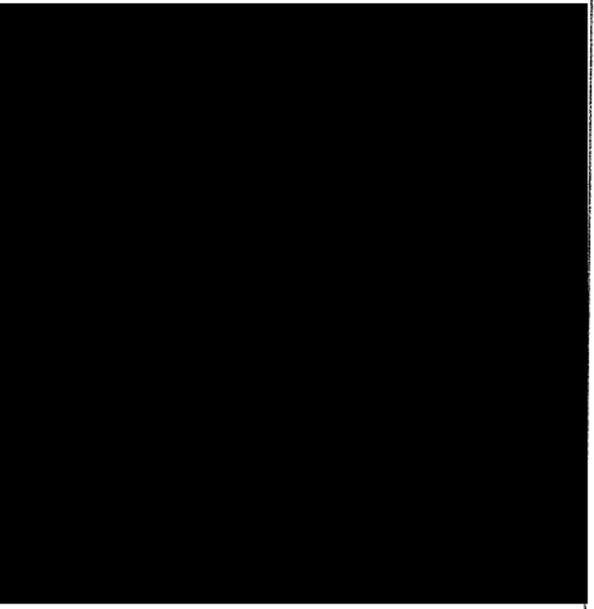| BORATOR ████████	LIER REPRESENTATIVE'S SIGNATURE *Program Director*	TITLE	(X6) DATE 1/5/16
ATE FOR ████	6899 K7VB11		If continuation sheet 1 of 2

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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9 179	Continued From page 1	9 179	Medication/Medical Change Sheet and then repeated back to prevent potential errors. To ensure no other residents were affected by this issue, PRN medication documentation for the past quarter was reviewed for all residents in the home to determine if the RN had been notified for any ineffective PRN administration. No other issues were identified. All staff in the Day Program and Residence was retrained. A systematic change to prevent recurrence is the requirement of the RN to request a physician's authorization for any desired changes to a physician's PRN medication order and the retraining of all staff on the need to follow the RN's instructions and notify the RN whenever a PRN medication is ineffective. To monitor this corrective action, the Resident Manager will observe and document on a monthly monitoring form three (3) times weekly for a period of two (2) months, the correct implementation of PRN documentation and following RN instructions. Monitoring documentation will be reviewed monthly by the Program Supervisor and located in the QA binder.	