	DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETED         12G036       B. WING       10/14/2022         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       10/14/2022         THE ARC OF MAUI - HALE KIHEI       STREET ADDRESS, CITY, STATE, ZIP CODE       179 HALE KAI STREET         K(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (xs)         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       COMPLET         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY)         E 000       Initial Comments       E 000       E 000       E 000       Feeduath Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,       E 000       ID       ID	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER         THE ARC OF MAUI - HALE KIHEI         STREET ADDRESS, CITY, STATE, ZIP CODE         179 HALE KAI STREET         KIHEI, HI 96753         (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) COMPLET DATE         E 000       Initial Comments       E 000         A recertification survey was conducted by the Office of Health Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,       E 000				. ,				
179 HALE KAI STREET KIHEI, HI 96753         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (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)       COMPLET COMPLET DEFICIENCY)         E 000       Initial Comments       E 000         A recertification survey was conducted by the Office of Health Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,       E 000			12G036	B. WING			10/	14/2022
THE ARC OF MAUI - HALE KIHEI         KIHEI, HI 96753         (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) COMPLET DATE         E 000       Initial Comments       E 000       E 000       A recertification survey was conducted by the Office of Health Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,       E 000	NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET DATE         E 000       Initial Comments       E 000       E 000       Initial Comments       E 000         A recertification survey was conducted by the Office of Health Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,       E 000	THE ARC	OF MAUI - HALE KIHEI						
A recertification survey was conducted by the Office of Health Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
Office of Health Care Assurance on October 14, 2022. The facility was found to be in substantial compliance with the requirements at §483.475,	E 000	Initial Comments		E	000			
		Office of Health Care 2022. The facility was compliance with the r	Assurance on October 14, s found to be in substantial equirements at §483.475,					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								

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.

# PRINTED: 10/24/2022

		ID HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		12G036	B. WING		1(	0/14/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
THE ARC	OF MAUI - HALE KIHEI			179 HALE KAI STREET KIHEI, HI 96753		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W O	00		
	the Office of Health C through 10/14/22. Th be in substantial com requirements of 42 Cl Intermediate Care Fa Intellectual Disabilities ACTs #9244 was inve unsubstantiated.	FR 440.150, Subpart I, cilities for Individuals with s (ICF/IID).				
	Census: 5 clients					
W 454	Sampled: 3 clients INFECTION CONTRO CFR(s): 483.470(I)(1)		W 4	54		
	, , ,	ide a sanitary environment transmission of infections.				
	Based on observation facility staff training, the sanitary environment transmission of infect before and after using in the kitchen. As a real	not met as evidenced by: ns, interviews, and review of he facility failed to provide a to avoid sources and ions by not washing hands g gloves while handling food esult of this deficiency, ransmission of food-borne				
	Finding include:					
	preparation gloves in	PM, Direct Service was observed wearing food the kitchen. DSP4 peeled aced the peeled bananas				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 10/24/2022

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.

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 10/24/2022 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE	
		12G036	B. WING			_	10/	14/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE ARC	OF MAUI - HALE KIHEI				79 HALE KAI STREET IHEI, HI 96753			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 454	gloves and banana per then took a pot of food emptied the food into empty pot and placed put on a new pair of for then proceeded to che grabbed the chopped hands, and placed the then discarded her glo then washed the cuttin back on the kitchen co pot of cooked carrots water from the pot in the carrots on the cutto on a pair of food prep proceeded to chop the then used her gloved carrots in the bowl. S and knife in the sink. gloves in the trash. D retrieved a tub of butto spoon to mix butter in carrots, and then cove On 10/12/22 at 5:13 F When inquired when I when using gloves, D supposed to wash the using gloves. DSP4 ther hands and then do preparation gloves should wash hands bo	SP4 then discarded her eels in the trash can. DSP4 d from the stovetop and a bowl. DSP4 then took the it in the sink. DSP4 then bod preparation gloves and op the bananas with a knife, bananas with her gloved e bananas in a bowl. She byes in the trash. DSP4 ng board, dried it, and put it bunter. DSP4 then took a off the stove, emptied the the sink, and then emptied ing board. DSP4 then put aration gloves. DSP4 then e carrots with a knife and hands to put the chopped he placed the cutting board She then discarded her SP4 then went to the fridge, er, got a spoon, used the to the bowl of chopped ered the bowl with foil. PM, DSP4 was interviewed. hands should be washed SP4 stated that they are ir hands before and after hen immediately washed onned a new pair of food	W	454				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: HI04IMR0036

If continuation sheet Page 2 of 3

		ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:					PLETED
		12G036	B. WING			10/	14/2022
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
THE ARC	OF MAUI - HALE KIHEI				9 HALE KAI STREET		
				KI	IHEI, HI 96753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 454	Continued From page cross contamination. On 10/14/22 at 09:10 TrainingFood Servi	AM, facility's "ICF/MR: Staff ice: Hand Washing and wed and stated, "Wash		454			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: HI04IMR0036

If continuation sheet Page 3 of 3

PRINTED: 10/24/2022 FORM APPROVED

Hawaii Dent	of Health	Office of Health	Care Assurance

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		12G036	B. WING		10	/14/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		179 HAL	E KAI STREET			
THE ARC (	OF MAUI - HALE KIHEI	KIHEI, H	96753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
9 000	INITIAL COMMENTS		9 000			
	State Survey Agency 14, 2022. The facility	as conducted by the Hawaii from October 12 to October was found not to be in we with the requirements of Subchapter 1.				
9 091	11-99-9(d)(2)(A) DIET	TETIC SERVICES	9 091			
	facility staff training, t food under sanitary c staff member not was	and served ions.				
	preparation gloves in some bananas and p on a cutting board. D gloves and banana pe then took a pot of foo emptied the food into empty pot and placed put on a new pair of f then proceeded to ch grabbed the chopped hands, and placed the then discarded her gl	PM, Direct Service was observed wearing food the kitchen. DSP4 peeled laced the peeled bananas DSP4 then discarded her eels in the trash can. DSP4 d from the stovetop and a bowl. DSP4 then took the d it in the sink. DSP4 then ood preparation gloves and op the bananas with a knife, bananas with her gloved e bananas in a bowl. She oves in the trash. DSP4 ing board, dried it, and put it				
ice of Health		ounter. DSP4 then took a				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Hawaii Dept. of Health. Office of Health Care Assura	nco

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		12G036	B. WING		10	/14/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
		179 HA	LE KAI STREET			
	OF MAUI - HALE KIHEI	KIHEI,	HI 96753			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
9 091	water from the pot in the carrots on the cutton a pair of food prep proceeded to chop the then used her gloved carrots in the bowl. S and knife in the sink. gloves in the trash. E retrieved a tub of butt spoon to mix butter in carrots, and then cover On 10/12/22 at 5:13 F When inquired when when using gloves, D supposed to wash the using gloves. DSP4 ther hands and then d preparation gloves. On 10/12/22 at 5:50 F with Case Manager (C whether DSP4 should and after using gloves should wash hands be in the kitchen becaus: cross contamination. On 10/14/22 at 09:10 TrainingFood Servit	off the stove, emptied the the sink, and then emptied ting board. DSP4 then put aration gloves. DSP4 then e carrots with a knife and hands to put the chopped she placed the cutting board She then discarded her OSP4 then went to the fridge, er, got a spoon, used the to the bowl of chopped ered the bowl with foil. PM, DSP4 was interviewed. hands should be washed SP4 stated that they are eir hands before and after then immediately washed onned a new pair of food PM, an interview was done CM). When inquired d have washed hands before s, CM stated that staff efore and after using gloves e not doing so can cause AM, facility's "ICF/MR: Staff fice: Hand Washing and wed and stated, "Wash ter use of gloves". CEEPING age areas shall	9 091			

# Hawaii Dept. of Health, Office of Health Care Assurance

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		12G036	B. WING		10	/14/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
THE ARC	OF MAUI - HALE KIHEI		E KAI STREET			
		KIHEI, F	II 96753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
9 149	Continued From page	2	9 149			
	facility policy and pro provide a locked stor- materials. As a resul facility's clients were potential exposure fro materials. Findings include:	n, interview, and review of cedures, the facility failed to age area for cleaning t of this deficiency, the put at risk for harm from om hazardous cleaning				
	Manager (CM). Durin and surveyor walked from the kitchen and of the house. In this was located to the left closed door was loca CM stated that the clo cleaning materials. C closet was unlocked of Two (2) bottles of Mr. (2) bottles of Clorox, cleaning spray, three alcohol, seven (7) co and two (2) spray bot cleaner was observed CM stated that the clo inquired if any clients closet, CM stated that have access to the cl the closet on their wa ask CM questions in	view was done with Case ng a tour of the house, CM through an unlocked door entered a separate hallway hallway, a closet with a door t and CM's office with a ted at the end of the hallway. oset holds the facility's Observed that the door to the when CM opened the door. Clean Cleaning Mist, two one (1) bottle of Windex (3) bottles of 70% Isopropyl ntainers of Clorox wipes,				
	On 10/12/22 at 3:40 l observed in the living	PM, C1 and C2 were room area. Observed C1				

Hawaii Dont	of Hoalth	Office of Health	h Care Assurance
	UI I ICAILII.		I Cale Assulance

AND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:		COM	E SURVEY PLETED
		12G036	B. WING		10	)/14/2022
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
			E KAI STREET			
HE ARC	OF MAUI - HALE KIHEI	KIHEI, H	II 96753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
9 149	walking throughout th and picking up and ha her hands with no def ease and answered of was observed walking no assistance. C2 wa electronic tablet unas conversed with staff a also observed to be a and drink it with ease On 10/14/22 at 09:18 Procedure Hazardous	e house with no assistance andling various items with ficits. C1 spoke to staff with guestions appropriately. C2 g throughout the house with as observed playing with an sisted and C2 periodically about his tablet. C2 was about his tablet. C2 was about his tablet. C2 was about his tablet. C2 was about his tablet. C2 was about his tablet. Was about his tablet. C2 was about his tablet. Was about his tablet. Was about his tablet. C2 was about his tablet. Was about his tablet. C2	9 149			