

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/21/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE ARC OF MAUI - HALE KANALOA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>450-B KANALOA AVENUE KAHULUI, HI 96732</b>
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(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) COMPLETION DATE
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W 000	INITIAL COMMENTS  A recertification survey was conducted by the Office of Health Care Assurance from May 19, 2021 to May 21, 2021. A facility reported incident (ACTS #8826) was also investigated and substantiated. The facility was not in compliance with 42 CFR 483 Subpart I.	W 000		
W 127	<p>Survey Census: 5</p> <p><b>PROTECTION OF CLIENTS RIGHTS</b> CFR(s): 483.420(a)(5)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.</p> <p>This STANDARD is not met as evidenced by: Based on review of facility reported incident, staff interview, observations, and review of records, the facility failed to ensure that Client (C) 1 was not subjected to physical abuse.</p> <p>Findings Include:</p> <p>On 05/19/21 at 08:30 AM a review of the facility reported incident revealed the following: 04/27/21 - staff witnessed physical abuse (staff to client, C1) while working at the facility several months ago. Staff did not report this because they were newer staff and afraid that the alleged perpetrator would be angry. However, staff could no longer live with this information and reported it to the Resident Manager (Mgr).</p> <p>During an interview with the Program Director</p>	W 127		6/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>06/15/2021</b>
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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.

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W 127	<p>Continued From page 1</p> <p>(Dir) on 05/19/21 at 09:30 AM, Dir acknowledged the abuse incident but stated that the facility had completed a full investigation and that measures had been taken, and were in place, to protect their clients and prevent this from happening again.</p> <p>Observations of all clients in the facility were made between 05/19/21 at 10:00 AM to 05/21/21 at 11:00 AM which did not reveal any abuse or punishment.</p> <p>On 05/21/21 at 11:00 AM, a review of the facility's full investigation conclusion showed the following measures taken: C1's guardian was notified of the incident, Adult Protective Services (APS) was made, safety measures against staff were taken, staff retraining regarding mandated reporting was done.</p>	W 127			