Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	A. BUILDING:					
		12G021	B. WING		06/14/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE ARC	IN HAWAII - 6 B		HANA STREET U, HI 96816	T		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
9 000	INITIAL COMMENTS		9 000			
	A re-licensing survey was conducted by the office of Healthcare Assurance on June 14, 2024. The facility was found not in compliance with Title 11, Department of Health Chapter 99.					
	Survey dates: June 1	2 to June 14 , 2024.				
	Census: Four clients					
Sample: Two clients						
9 005	11-99-4(a) ACTIVE T	REATMENT PROGRAM	9 005			
	A plan of treatment shall be developed and implemented for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional, and vocational level. This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure two of two clients (Client (C) 1 and C2) sampled were provided with continuous active treatment. The Direct Service Provider's (DSP)'s did not address one client (C)1's targeted behavior of agitation and hitting his head. The DSP's did not provide interventions to redirect or offer other support. The DSP in the day program did not provide informal opportunities to teach C2 to gather her lunch supplies, pour her water, and put away her lunch supplies.					
	Findings include:					
	On 06/12/24 at 11:56 AM, observed C2 in the classroom during lunch. DSP1 took out C2's lunch box from the refrigerator and sat next to C2. DSP1 took out the lunch items and poured					

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

TITLE (X6) DATE

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		12G021	B. WING		06/1	4/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
THE ARC	IN HAWAII - 6 B		HANA STREET	Г		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETE DATE
9 005	ME OF PROVIDER OR SUPPLIER E ARC IN HAWAII - 6 B SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		9 005			

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STATE FORM 6899 If continuation sheet 2 of 6 ZISW11

Hawaii Dept. of Health, Office of Health Care Assurance

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		12G021	B. WING		00	6/14/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	•	
THE ARC	IN HAWAII - 6 B		AHANA STREET			
		HONOLU	JLU, HI 96816			
(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 ACTI) CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
9 005	Continued From page 2		9 005			
	the living room, hitting several times. DSP3 sitting at the table wit "C1 stop hitting yours louder. C1 was not co	C1 sitting in the soft chair in g his head with his fist and DSP4 were observed h C2 and C4. DSP3 said, self." C1's chanting became observed to listen to books or oy, except the soft bongo for				
	reviewedhitting hea behavior. Redirect C stop hitting himself. I staff may gently hold "stop hitting." Reassu help himstaff shoul and engage him in ca enjoys such as humn	dent plan dated 04/05/2023 d. Staff response to 1 and verbally cue him to f C1 continues to hit himself his hand down and say, are C1 that you are there to d continue to reassure him alming, soothing activities he ning, singinglistening to to take C1 for a short walk.				
	Intermediate Care Fa (CM). The surveyor a program is addressin agitation. The CM ex home will take him fo environment and try the's chanting loudly. also likes music. It is himself, I think we man	g C1's behaviors of cplained that the staff in the				
	with the HM the surve working in the home: he is hitting his head that we re-direct him	AM, during a telephone call eyor asked how the staff should respond to C1 when or agitated. The HM stated from hitting his face. We hen we take him outside.				

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STATE FORM STATE FORM If continuation sheet 3 of 6

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		12G021	B. WING		06/14/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
THE ADO	IN	852-A PA	AHANA STREET	ī	
THE ARC	IN HAWAII - 6 B	HONOLUI	_U, HI 96816		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
9 005	Continued From page	e 3	9 005		
	Sometimes he sits in the rocking chair with music. He has his radio; he loves Hawaiian music. The surveyor shared the observations during the home visit on 06/12/24 when C1 was hitting his head and that the DSP's responded by saying "C1, don't hit your head." and did not provide additional support.				
9 091	9 091 11-99-9(d)(2)(A) DIETETIC SERVICES		9 091		
	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 interview with staff members, the facility did not ensure the refrigerators' temperature containing client foods were monitored and ensure all foods were stored to prevent expired food items.				
	7 and 8's refrigerator thermometer in their 8's thermometer was read 43 degrees Fah Provider (DSP) 2 con above 41 degrees F. thermometer inside the classroom 7 refriginquired with DSP1 at temperature logs, the the logs and stated the 2) On 06/12/25 at 02 an opened ranch saladate, 04/12/24. A write	y were not able to provide			

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(X3) DATE SURVEY

Hawaii Dept. of Health, Office of Health Care Assurance

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		12G021	B. WING		06/14/2024		
THE ARC IN HAWAII - 6 B			DDRESS, CITY, STATE, ZIP CODE AAHANA STREET JLU, HI 96816				
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9 091	out. HM opened the pranch salad dressing containers of unopen	e was the date it was pulled antry and found another past the best by date. Two ed peach yogurt were found a best by date of 06/10/24.	9 091				
9 199	Discontinued and out containers with worn, missing labels shall b the pharmacy or drug disposition. This Statute is not meased on observation failed to discard an exclient (C)3 of four clie. Findings include: On 06/12/24 at 6:00 Fadministration observed Direct support profess administering the medication, it was 05/2024. DSP4 immediscarded the tablet frexplained that C4's measured will be made to C3's reconstruction.	illegible, or e returned to room for proper et as evidenced by: and interview, the facility spired medication for one ints sampled. PM, medication ation in the home with sional (DSP4) 4. DSP4 was dication for C3. The in the medication cup. spected the package with found to be expired on ediately removed and form the medication cup and form the medication cup and form purchases his vides them to the home. ensure that a telephone call mother. AM, discussion with the date should be checked	9 199				

(X2) MULTIPLE CONSTRUCTION

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Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		12G021	B. WING		06/14/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE ADO	IN HAMAH CD	852-A PAA	HANA STREET	г		
THE ARC	IN HAWAII - 6 B	HONOLULI	J, HI 96816			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	

Office of Health Care Assurance

STATE FORM 2ISW11 If continuation sheet 6 of 6