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
	12G036	A. BUILDING: _____ B. WING _____	10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC OF MAUI - HALE KIHEI	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) COMPLETE DATE
9 000	INITIAL COMMENTS A licensure survey was conducted by the Office of Health Care Assurance on 10/27/23. The facility was found not to be in substantial compliance with the regulatory requirements at Title 11, Chapter 99.	9 000		
9 093	11-99-9(d)(2)(C) DIETETIC SERVICES Perishable foods shall be stored at the proper temperatures to conserve nutritive values and prevent spoilage. This Statute is not met as evidenced by: Based on observations and interview with staff, the facility did not assure perishable food were stored at the proper temperatures to conserve nutritive values and prevent spoilage. The refrigerators were not within the specified parameters set by the facility. Findings include: On 10/25/23 at 01:25 PM, observed two refrigerators in the kitchen, labeled as "A" and "B". The temperature of refrigerator A (RA) was 50 degrees and refrigerator B (RB) was 55 degrees. Review of the signage on RA noted acceptable temperature range for refrigerators was 34 to 38 degrees Fahrenheit. Subsequent observations done on 10/25/23 at 04:40 PM (RA = 50 degrees and RB = 55 degrees), 10/26/23 at 08:46 AM (RA = 48 degrees and RB = 60 degrees), and 10/26/23 at 11:52 AM (RA = 40 degrees and RB = 50 degrees) found the temperatures were out of acceptable range. On 10/26/23 at 02:02 PM concurrent observation was done with ICF Manager of temperatures for the refrigerators. RA read at 55 degrees and RB	9 093		

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/07/23

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9 093	Continued From page 1 at 45 degrees. The Manager reported he will purchase new thermometers. The log for documenting temperatures, noted temperatures are taken weekly and could not locate the temperature log for RB.	9 093		
9 109	11-99-11(c)(2) RESIDENT DAILY LIVING CARE AND TRAINING The facility staff shall provide at least the following: Physical care and assistance to keep residents clean, comfortable, well-groomed, and protected from accidents and infections. This Statute is not met as evidenced by: Based on observation and interview with staff members, the facility did not assure staff demonstrated competency to safely transfer Client (C)2 from bed to wheelchair. The wheelchair brakes were not engaged during the transfer resulting in potential for the client to fall if the wheelchair slipped out from under him. Findings include: On 10/25/23 at 02:30 PM, Direct Care Staff (DCS)3 completed peri-care for Client (C)2 and called for assistance to transfer the client from the bed to the wheelchair. The wheelchair was placed close to the bed, C2 was assisted to sit up in bed. DCS1 entered the room to assist. C2 was manually lifted by staff from bed to the wheelchair. The wheelchair was observed to swivel during the transfer. While applying the footrests, the wheelchair continued to move. Observed the wheelchair brakes were not engaged.	9 109		

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9 109	Continued From page 2 On 10/26/23 at 01:15 PM, observed a mechanical lift in C2's room. Interviewed DCS2 regarding the use of the lift. DCS2 reported staff have been trained and approved to do two-person transfer. DCS2 confirmed the wheelchair brakes should be engaged during the transfer and positioning of the client. On 10/27/23 at 08:50 AM an interview was conducted with Registered Nurse (RN). Inquired whether C2 requires the use of a mechanical lift for transfers. RN responded staff may use the mechanical lift or two-person transfer. Further queried whether the brakes of the wheelchair should be engaged during the transfer. RN replied brakes should be locked for safety as the wheelchair can roll out from under the client.	9 109		
9 279	11-99-29(a)(10) RESIDENT'S RIGHTS Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall: Be treated with consideration, respect and full recognition of their dignity and individuality, including privacy in treatment and in care. This Statute is not met as evidenced by: Based on observation, the facility did not assure	9 279		

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9 279	Continued From page 3 privacy was provided during personal care for 1 of 3 clients in the core sample. Findings include: On 10/25/23 at 02:30 PM, the door to Client (C)2's room was open. Observed C2 lying in bed wearing a t-shirt and personal brief. Direct Care Staff (DCS)3 confirmed that she would be changing the client's personal brief. Observed C5 ambulating in the hall and stood by the wall close to C2's room (hall exit with curtains). A staff member commented to C5, what are you doing and prompted C5 to return to the living room. During care, the door was left open, staff member was heard telling C2 what she was doing throughout the brief change. Upon approach to the door, C2 was observed from the hallway lying in bed with personal brief exposed. DCS3 then put C2's shorts on.	9 279		