STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC IN HAWAII - 6 A	**852 PAAHANA STREET , HONOLULU, Hawaii, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A focused fundamental recertification survey was conducted by the Office of Health Care Assurance on 06/12/24 - 06/14/24. The facility met the Health Safety Requirements of Appendix "Z"; in accordance with 42 CFR §483.475, Condition of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities, Emergency Preparedness.	E0000		
W0000	INITIAL COMMENTS A focused fundamental recertification survey was conducted by the Office of Health Care Assurance. The facility was to be in substantial compliance with the requirement at 42 CFR §483, Subpart I. A Facility Reported Incident (FRI) from the Aspen Complaints/Incidents Tracking System(ACTS) was investigated, ACTS #10949. There was no deficient practice identified related to the FRI. Survey Dates: 06/12/24 to 06/14/24 Survey Census: 4 Clients Sample Size: 2 Clients	W0000		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE