

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G036		(X2) MULTIPLE CONSTRUCTION A. BUILDING BU - THE ARC OF... B. WING		(X3) DATE SURVEY COMPLETED 01/23/2024	
NAME OF PROVIDER OR SUPPLIER THE ARC OF MAUI - HALE KIHEI				STREET ADDRESS, CITY, STATE, ZIP CODE 179 HALE KAI STREET 140 N MARKET ST, SUITE 202B, WAILUKU, HI 96793, KIHEI, Hawaii, 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) COMPLETION DATE
K0000 Bldg. BU	INITIAL COMMENTS A desk review follow-up was conducted on 01/17/24 with the program manager at the Arc of Maui. The organization has joined HAH and will be participating in multi-agency drills. E-039 was found to be corrected. Date of survey was 12/5/23.			K0000			

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
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E0000	Initial Comments No Information	E0000			

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