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 07/07/2023

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 recertification survey was conducted by the Office of Health Care Assurance from July 5, 2023 to July 7, 2023. The facility met the conditions of participation for 42 CFR 483.475, Emergency Preparedness (Appendix Z) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	E0000		
W0000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance on July 7, 2023. The facility was found not to be in compliance with 42 CFR 483, Subpart I. The census was four clients. A sample of two clients were selected.	W0000		
W0268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is NOT MET as evidenced by: Based on observations, record review, and interview with staff member the facility failed to engage with an unsampled client (Client (C) 3) to promote client growth, development, and independence during day program. Findings include: On 07/05/23 at 09:50 AM at day program, observed client's in the classroom participating in a exercise program that was put on the television. Observed Direct Support Worker (DSW) 1 walking around then sitting down without interacting with clients performing any task. C3 was observed to be facing away from the other clients toward a wall. C3 was encouraged to participate, was not adjusted and	W0268		

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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W0268	Continued from page 1 positioned in her wheelchair to see what the other clients were doing. At 10:05 AM, DSW1 grabs a container of items and without talking or explaining to C3, brings the item in front of C3 to participate. Each time DSW1 takes one item from the bin for C3 to use he takes them away without informing C3 they will move on to another item. At 10:13 AM, DSW1 suddenly takes the container of items and puts them away without informing C3 and takes her to another room to be changed without explaining to C3 what they will be doing next. When C3 returns to the classroom, DSW1 adjusted C3's chair's angle backward then forward abruptly, C3's head is seen to be thrown back and forth during the adjustment due to the abruptness. DSW1 was not observed to inform C3 that he will be adjusting her chair. Review of C3's Individual Program Plan under "Adaptive Behavior/Independent Living" date 01/13/22, documents "Active Treatment is involving ...[C3] ...at her highest level of functioning. Even if she needs maximum physical assistance in ADL [Activities of Daily Living] ...engaging with ...[C3] ...,talking with her and explaining what you are doing is involving her in her self-care and is active treatment." On 07/07/23 at 09:38 AM interview with Case Manager (CM) was done. CM reported staff should ensure clients' who need more physical support should be involved with group activities and should have involved C3 with exercises by helping her with Range of Motion (ROM) or at least facing the group because C3 does enjoy socializing. CM confirmed staff members should talk to C3 and explain to C3 what they are doing.	W0268		
W0352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is NOT MET as evidenced by: Based on record review and interview with staff member, the facility failed to ensure one of two client's (Client (C) 2) sampled received dental services at least annually. Findings include:	W0352		

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W0352	Continued from page 2 Review of C2's health record documented the last dental service C2 received was on 04/04/22, past the annual date. On 07/07/23 at 09:15 AM interview with Registered Nurse (RN) was done. RN confirmed C2's last dental appointment was on 04/04/22 and is past the annual date.	W0352		
W0369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is NOT MET as evidenced by: Based on observations, interviews, and record review the facility failed to provide drug administration without error to one of two clients sampled. This failed practice has the potential to cause significant adverse effects to all the clients in the facility. Findings Include: Observation was conducted on 07/05/23 at 05:10 PM in the kitchen. Home Manager (HM) was observed administering medications to Client (C) 1. In reviewing the prescribed dosage and instruction, it was observed that the medication bottle and C1's Medication Administration Record (MAR) both indicated, "Take 1 tablet by mouth once daily at 4pm." When HM was asked the parameters of the timing to administer C1's medications, she answered that it was one hour before and one hour after the scheduled time. HM was informed that C1's medication was administered at 05:10 PM and was asked if that was within the parameters. HM answered that it was not within the one-hour time span. A review of the facility's policy and procedure, "Medication Administration Procedure," dated 02/23 documented, "CHECK THE 5 RIGHTS for all the medications in the following manner ...3. Right TIME ...Check each medication to be given at that time."	W0369		

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W0369	Continued from page 3 An interview with Registered Nurse (RN) was conducted in the facility classroom on 07/07/23 at 09:15 AM. RN was asked what the parameters were for administering medications at the right time. RN verbalized, "one hour before and one hour after." RN was informed of the physician order, "Quetiapine 50mg tabs take one tab by mouth once daily at 4pm." RN was also informed that the medication was administered to C1 at 05:10 PM. RN agreed that it was a medication error because it was given late. RN confirmed, "It's an error if we follow the one hour before and one hour after rule."	W0369		