STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **07/17/2023**

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
K0000 Bldg. 01	INITIAL COMMENTS A recertification LSC survey was conducted by DOH OHCA on 7/17/23. The facility was found not in compliance with Title 42 CFR, Chapter 4. The following citations were a result of this survey.	K0000		
KS347 Bldg. 01	Smoke Detection CFR(s): NFPA 101 Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 1. Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, that uses quick-response or residential sprinklers, with existing battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3.	KS347		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G020	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - BUILDING 0...** B. WING	(X3) DATE SURVEY COMPLETED **07/17/2023**

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KS347 Bldg. 01	Continued from page 1 This STANDARD is NOT MET as evidenced by: K-347 Smoke Alarms This STANDARD is not met as evidenced by: Based on record review and interview with staff members, the facility failed to provide documentation for the monthly smoke alarm inspection and testing in accordance with NFPA 101, 2012 edition, section 9.6.2.10 and NFPA 72, 2010 edition, section 14.4.6. This deficiency could affect all residents, staff and visitors during with a possible delayed or no response from the smoke alarms located within the facility. Findings include: During record review and facility survey on 7/17/23 at approximately 1:45 pm revealed that the facility failed to provide documentation for a monthly smoke alarm inspection and testing. These findings were verified at the exit conference with the Program Manager on 7/17/23 at 2:15 pm.	KS347		

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E0000	Initial Comments A recertification LSC survey was conducted by DOH OHCA on 7/17/23. THIS FACILITY MET THE LIFE SAFETY REQUIREMENTS OF APPENDIX "Z"; IN ACCORDANCE WITH CFR 483.475, CONDITION OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID).	E0000		

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