STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC IN HAWAII - EWA B	**91-824 B HANAKAHI STREET , EWA BEACH, Hawaii, 96706**

(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 04/10/24 - 04/12/24. 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 on 04/10/24 - 04/12/24. The facility was found not to be in substantial compliance with the requirement at 42 CFR §483, Subpart I. Survey Dates: 04/10/24 - 04/12/24 Survey Census: 5 Clients Sample Size: 5 Clients	W0000		
W0108	COMPLIANCE W FEDERAL, STATE & LOCAL LAWS CFR(s): 483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to safety, and This STANDARD is NOT MET as evidenced by: §11-99-14 Housekeeping. (h) Sufficient locked storage areas shall be provided for all cleaning materials and equipment. Based on observation and interview, the facility failed to comply with Hawaii Administrative Rule §11-99-14(h), as evidenced by an unlocked storage	W0108		

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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W0108	Continued from page 1 closet containing caustic cleaning materials which were accessible to 2 of 5 clients (Clients 3 and 5), who were not under constant supervision. Findings include: On 04/11/24 at 06:00 AM, observed the cleaning supply closet in the laundry room unlocked with the key still in the lock. At 06:52 AM, observed that Direct Support Personnel (DSP)8 was in the bathroom, unable to visualize C3 and C5 in the living room. DSP6 was in the kitchen, with her back to the living room, and Home Manager (HM)1 was outside getting Client (C)2 off the transport bus and bringing her back in the home. C3 and C5 were observed independently ambulating and wandering around the living room. The cleaning supply closet remained unlocked. At 06:56 AM, Surveyor went to open the unlocked cleaning supply closet to observe what was inside. In addition to bleach, observed various other caustic cleaning supplies for the home, both liquid and powder. Both DSP6 and DSP8 took notice of Surveyor at the cleaning supply closet and acknowledged that it should not have been left unlocked.	W0108		
W0109	COMPLIANCE W FEDERAL, STATE & LOCAL LAWS CFR(s): 483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to sanitation. This STANDARD is NOT MET as evidenced by: §11-99-9 Dietetic services. (d) Food services, planning, and storage. (2) Storing and handling of food: (B) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or waste-water backflow, or contamination by condensation, leakages, rodents, or vermin. Based on observation, interview, and record review, the facility failed to comply with Hawaii Administrative Rule §11-99-9(d)(2)(B), as evidenced by emergency staple food items for 2 of 5 clients (Clients 1 and 4), stored directly on the floor of the	W0109		

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W0109	Continued from page 2 emergency food closet. Findings include: On 04/10/24 at 02:40 PM, observed emergency food supply closet with Direct Support Personnel (DSP)7. DSP7 confirmed 3 cases of pureed food on the floor of the closet was for clients. On 04/10/24 at 03:18 PM, an interview was done with Home Manager (HM)1 in the living area. HM1 confirmed that the bottles of pureed food on the floor of the emergency food supply closet was for Client (C)1 and C4 because they required a pureed diet. HM1 reported that she was unaware that the pureed food bottles should be kept off the floor. Review of the facility Food Storage and Rotation policy and procedure, dated 08/2019, noted that the Home Manager is responsible to "Store all food in a cool, dry, dark place off of the ground."	W0109		
W0192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure all staff received the required annual trainings, specifically in accident prevention and infection control. As a result of this deficient practice, the staff did not have the trainings/ evaluations to perform their duties effectively, efficiently, and competently. Findings include: A review of the annual trainings for the Direct Support Personnel (DSP) in the home noted that DSP7 and DSP4 were both overdue for their annual trainings in Accident Prevention. DSP7 was documented as last trained on 03/28/23, and DSP4 on 03/30/23. In addition, in a review of the training attendees, it was noted that DSP3 and DSP6 were also overdue for their annual Infection Control (IC)	W0192		

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W0192	Continued from page 3 training. On 04/12/24 at 09:00 AM, the Human Resources Assistant reported that per the Training Coordinator, with regards to the Accident Prevention training, although it had been over a year since the last training (for DSP7 and DSP4), the trainings are "due annually so there is still time." Interview with the Nurse Manager (NM) at 01:15 PM outside her office validated that it was the facility practice that only a Nurse could conduct the IC training, including make-up trainings for staff who missed the annual training. NM acknowledged that both DSP3 and DSP6 were overdue for their annual IC training and confirmed that she did not conduct any make-up trainings for them in the last year. Interview with the Program Manager at 02:00 PM in the Conference Room confirmed that if it had been over a year since the last required training, then the training was overdue. Surveyor clarified with the Program Manager that it was the facility practice to ensure annual trainings did not exceed 12 months between trainings. A review of the facility's Annual Training Requirements policy and procedure, last revised on 12/18/23, noted that for all staff working with the clients in the home, Accident Prevention and Infection Control trainings were mandated annually.	W0192		
W0322	PHYSICIAN SERVICES CFR(s): 483.460(a)(3) The facility must provide or obtain preventive and general medical care. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 5 clients (Client 3) received the preventive and general health care she required as evidenced by an overdue colonoscopy. As a result of this deficient practice, Client 3 was placed at risk of delayed identification of potentially dangerous abnormalities in her colon. Findings include:	W0322		

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W0322	Continued from page 4 Record review of Client (C)3's medical record revealed a history of colon polyps. Last colonoscopy done on 11/18/16 with a physician recommendation to repeat the colonoscopy in 5 years, making it due at the end of 2021. An interview was done with the Nurse Manager (NM) in the Conference Room on 04/12/24 at 02:21 PM. NM acknowledged C3's history of colon polyps and confirmed that the colonoscopy follow-up was not done as recommended and was overdue.	W0322		
W0323	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(i) The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 clients (Client 5) received a vision exam annually. As a result of this deficient practice, Client 5 was placed at risk of delayed identification of changes in his vision requiring timely intervention/correction. Findings include: Record review of Client (C)5's medical record revealed his last eye/vision exam was done on 09/13/22. Although C5 did have a physical exam done on 10/23/23, his vision was not assessed at that time. On 04/12/24 at 10:41 AM, an interview was done with the Nurse Manager (NM) in the Conference Room. NM confirmed that vision exams should be done annually and acknowledged that C5's was overdue.	W0323		
W0368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.	W0368		

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W0368	Continued from page 5 This STANDARD is NOT MET as evidenced by: Based on observation, staff interview and record review the facility failed to administer insulin to Client (C) 1 as ordered by the physician, by having another staff verify insulin dose before it was given. Findings include: On 04/10/24 at 05:57 PM, observed Direct Support Professional (DSP) 5 take out C1's medication basket from the locked cabinet, show C1 her medication basket which has her name and picture on it and tell her she was going to give her insulin. DSP5 checked C1's blood glucose level which was 227. DSP5 calculated C1's insulin dose was 8 units per the ordered sliding scale and set the insulin pen to this dose. Site was selected, cleaned with an alcohol swab and dose given which C1 tolerated well. On 04/12/24 reviewed C1's April 2024 Physician Orders and found an order for cosign= person who verifies insulin dose. On 04/12/24 at 10:05 AM interviewed Nurse Manager (NM) who confirmed the order for C1 which stated cosign= person who verifies insulin dose means a second staff has to verify the insulin dose is correct prior to giving it. This was not observed being done on 04/10/24 at 05:57 PM when DSP5 gave C1 her insulin. Inquired of NM if DSP5 had received training on medication administration and she confirmed DSP5 had been provided the training on medication administration. NM provided documentation DSP5 attended Medication Administration training on 07/11/23. NM also provided documentation that HM1 and DSP5 attended the Hypoglycemia + Hyperglycemia Training & Insulin (New Order), Use Manual if BS [blood sugar] less than 70 & greater than 300 on 03/14/24. Record review of C1's Medication Administration Record (MAR) found 34 opportunities for a cosign for Humalog Kwikpen insulin doses from 04/01/24 - 04/12/24, three doses a day for 11 days and one dose on 04/12/24. C1 receives insulin three times a day at 5:00 AM, 11:00 AM and 5:00 PM. 24 spaces were signed by the same staff who administered C1's insulin. 10 spaces that required a cosign were signed by a different staff who did not sign as	W0368		

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W0368	Continued from page 6 giving the insulin.	W0368		
W0389	DRUG LABELING CFR(s): 483.460(m)(1)(ii) Labeling for drugs and biologicals must include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to label blood glucose testing strips with the opened on date and discard by date for Client (C) 1 and C2 and failed to write the date opened and date expired on the insulin pen for C1. Findings include: On 04/10/24 at 04:59 PM, C2 had her blood glucose test performed by Direct Support Professional (DSP) 5. During this time looked at the container of testing strips (Free Style Lite blood glucose test strips) for C2 and found there was no open date on the test strip container and no discard by date. At this time interviewed DSP5 and inquired how long the test strips are good for after they are opened and she stated she did not know. On 04/10/24 at 05:27 PM requested to see C1's glucometer (blood glucose monitoring machine) and test strips. DSP5 brought out the glucometer and test strips. The One Touch Verio Test strips container had "discard six months after opening" printed on the label. There was no opened on date written on the container of test strips. At this time interviewed DSP5 and inquired when the test strips were opened and she said she did not know when they were opened. On 04/10/24 at 05:35 PM, interviewed the Home Manager (HM) 1 who confirmed they are supposed to have the opened on and discard by date on blood glucose test strips. Inquired if there are quality checks done with the glucometers (blood glucose monitoring machine) and HM1 stated it is done when new test strips are opened. HM1 looked for the dates when the quality checks were done for C1 and C2's glucometers. HM1 was unable to find the quality check last done for C1. HM1 stated it might have been a weekend staff who did this.	W0389		

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W0389	Continued from page 7 On 04/10/24 at 06:08 PM, interviewed HM1 and inquired why C1's Humalog Kwikpen (insulin pen) did not have the date opened and date expired written on the insulin pen. Showed HM1 where this information is to be written on the pharmacy label that is provided on the insulin pen. HM1 stated she did not know insulin had to have an opened on and discard by date. HM1 stated she believes insulin is good for 30 days. A review of the manufacturer's storage recommendations for C1's Humalog Kwikpen revealed it has to be thrown away 28 days after first use.	W0389		
W0454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to prepare clients' meals in a sanitary manner putting them at risk for food borne illnesses. Findings include: 1) On 04/10/24 at 04:30 PM observed Direct Support Professional (DSP) 7 open salmon fillet packets and with ungloved hands placed them on a foil lined pan. DSP7 seasoned the salmon and used her ungloved finger tips to press the seasoning down onto the fillets. At this time interviewed DSP7 and inquired about her gloveless hands while handling food. DSP7 stated it was her first day cooking in the house. Inquired if she had orientation to cooking in the house and she stated she observed other staff. Inquired if she observed other staff cook without wearing gloves and she confirmed this. On 04/10/24 at 04:54 PM interviewed House Manager (HM) 1 regarding new staff orientation to cooking and cleaning in the home. HM1 confirmed she does orientation with new staff and confirmed staff are to use gloves when handling meat. HM1 showed DSP7 where the gloves are kept in the kitchen for staff to use when handling food. 2) On 04/10/24 at 05:00 PM observed DSP7 remove	W0454		

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W0454	Continued from page 8 the pan of salmon from the oven. Interviewed DSP7 at this time and inquired how she knows the fish is done. DSP7 stated she looks at the color of the fish and the flakiness. DSP7 stated she did not know she was supposed to check the temperature of the fish when inquired. DSP7 stated she would "touch it" to check for doneness. Suggested DSP7 inquire of the HM1 how she would check to assure the salmon was ready for clients to eat. HM1 came into the kitchen and showed DSP7 where the thermometer was kept and showed her how to test the temperature of the salmon fillets. HM1 stated fish is done at 145 degrees. On 04/12/24 at 09:36 AM interviewed Nurse Manager (NM). Inquired if DSP7 had attended training for infection control and handling and cooking food for the clients. NM stated DSP7 attended the recent annual Infection Control Training she provided to the staff. NM was able to provide the record when DSP7 attended this training, 03/19/24 from 09:04 AM - 10:49 AM. Reviewed the copy of the Infection Control Training 2024 PowerPoint the NM provided and found there is a section titled Food Safety and Handling. One slide states Use cooking gloves when handling meat and poultry. Use tongs or proper kitchen equipment when handling food. Another slide states Cook food to minimal cooking temperature before serving 145 degrees F (Fahrenheit) - fish, whole pieces of pork and beef (roast). The next slide states USDA Recommended Safe Minimum Internal Temperatures Fish 145 degrees F (Fahrenheit).	W0454		
W0473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview the facility failed to prepare clients' meals at the appropriate temperature, putting them at risk for food borne illnesses. Findings include: On 04/10/24 at 05:00 PM observed DSP7 remove a pan of salmon from the oven and was getting ready to prepare the salmon per the clients' diet consistency. Interviewed DSP7 at this time and	W0473		

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W0473	Continued from page 9 inquired how she knows the fish is done. DSP7 stated she looks at the color of the fish and the flakiness. DSP7 stated she did not know she was supposed to check the temperature of the fish when inquired. DSP7 stated she would "touch it" to check for doneness. Suggested DSP7 inquire of the HM1 how she would check to assure the salmon was ready for clients to safely eat. HM1 came into the kitchen and showed DSP7 where the thermometer was kept and showed how to test the temperature of the salmon fillets. HM1 stated fish is done at 145 degrees. Pan of salmon was placed back in the oven to finish cooking. On 04/12/24 at 09:36 AM interviewed Nurse Manager (NM). Inquired if DSP7 had attended training for infection control and handling and cooking food for the clients. NM stated DSP7 attended the recent annual Infection Control Training she provided to the staff. NM was able to provide the record showing DSP7 attended this training, 03/19/24 from 09:04 AM - 10:49 AM. Reviewed the copy of the Infection Control Training 2024 PowerPoint the NM provided and found there is a section titled Food Safety and Handling. One slide states Cook food to minimal cooking temperature before serving 145 degrees F (Fahrenheit) - fish, whole pieces of pork and beef (roast). The next slide states USDA Recommended Safe Minimum Internal Temperatures Fish 145 degrees F (Fahrenheit).	W0473		