STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC IN HAWAII - EWA C	**91-824 C 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
W0000	INITIAL COMMENTS An abbreviated survey was conducted by the State Agency (SA) from 03/10/25 through 03/11/25 to investigate facility reported incidents (FRI) Aspen complaint tracking system (ACTS) intake #11482 and #11486. The facility was found not to be in compliance with 42 CFR 440.150, Subpart I, Condition of Participation (COP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	W0000		
W0111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to contain an accurate account of all information relevant to the actual experience of the client in the facility for one of one client (Client (C) 1) sampled. As a result of this deficient practice, not all pertinent information was available to caregivers and provider to monitor her condition. Findings include: C1 is a 49-year-old female who resides in an intermediate care facility for individuals with intellectual disabilities. At baseline, she is alert and oriented to self, ambulatory and can carry a conversation. She has a history of chronic kidney disease (CKD), intermittent explosive disorder, kidney transplant, unspecified delay in development, hypertension and intellectual disability. C1 had a suprapubic catheter (a tube that drains urine from your bladder through a small incision in your abdomen).	W0111		

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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W0111	Continued from page 1 On 02/10/25, the State Agency (SA) received a report from the facility that included the following information: "At approx. [approximately] 0600, Nurse Manager [NM] and Home Manager [HM] notified contacted Writer regarding...[C1's] ...change of condition. Per staff, vital signs were as followed [sic]: BP [blood pressure] 122/57 mmHg. [millimeter of mercury] RR [respiration rate] 21 rpm [respirations per minute]. HR [heart rate/pulse] 141 [normal 60-100]. Temp [temperature] 97.3 degrees F [Fahrenheit]. O2 [oxygen level in blood] 60-87% [normal 95-100%]. Nurse Manager informed and advised staff to call 911. EMS [Emergency Medical Service] services arrived and transported Client to hospital. Upon arrival to ER [Emergency Room], Client was assessed and admitted to the hospital." Review of C1's shift notes revealed on 02/09/25 at 07:27 AM, Direct Support Professional (DSP) note: "C1 was doing fine throughout the night she wake [sic] up but very sleepy." Vital signs noted at 06:32 AM documented pulse (PR) 134 and BP 122/52 mmHg. There was no oxygen saturation or respiratory rate documented at this time, and no other record of additional vital signs including oxygen saturation recorded that day, except on the event report. The notes did not include the HM and NM were contacted and that C1 was transferred to the hospital by ambulance. Reviewed the facility "General Event Report" regarding the change of condition, which included the following information: DSP1 note: "she...[C1] ...was sleeping and time to wake up then when i put her to her [sic] chair she was looking really tired. Then i check her vitals. BP 122/57 mmHg, respiratory rate: 21/min [minute], PR: 141/min, temperature: 97.3 F. O2 fluctuating at 60-87. Then we call the nurse to inform, then we monitor her oxygen. Oxygen level is going up and down and remain below 90%. Nurse told us to call 911. ..." "Corrective Actions Taken: monitor and call nurse and 911." NM note: 02/09/25 at 05:50 AM: "Staff reported that...[C1] ...was looking really tired when they got her up to get ready for morning medications and breakfast. Staff mentioned they immediately took the	W0111		

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W0111	Continued from page 2 vital signs and results were listed above. Notified the Home manager and RN [Registered Nurse]. Upon notification, RN advised staff to repeat vitals check. Not much change noted on second check, Oxygen saturation remained low and Pulse rate still elevated, and level of consciousness is not at baseline. Advised staff to call 911...[C1] ...was transported to..." the ER. On 03/11/25 at 10:30 AM, conducted a telephone interview with HM. She said the staff are expected to chart every shift and it should be a brief summary of what occurred that shift. She went on to say any vital signs taken, including the pulse oximetry (oxygen saturation level/PO2) should be recorded. HM said she knows the vitals had been rechecked and agreed they should have been documented, as well as the fact that C1 was different from her baseline and that she was transferred to the hospital by ambulance.	W0111		
W0342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to include training on the importance of low blood pressure as a key indicator of the client's health and monitoring for change of condition. In addition, there is lack of evidence the Direct Support Professional (DSP) staff recognized that one of one client (Client (C) 1) sampled had a trend of a rapid pulse rate and reported it to a nurse. As a result of these deficiencies, there was a delay in obtaining medical treatment to address C1's change of condition. Findings include: 1) Reviewed the power point the facility used for training, which included, but not limited to the following specific information:	W0342		

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W0342	Continued from page 3 - "Vital Signs. Clinical measurements, specifically pulse rate, temperature, respiration rate and blood pressure, that indicate the state of the person's essential body functions." - "Heart rate: Normal heart rate or pulse rate: 60-100 beats per minute (bpm). ...Elevated heart rate (above 100 bpm) - TACHYCARDIA ...Slow heart rate (lower than 60 bpm) - BRADYCARDIA ..." - "Blood Pressure (BP). Normal blood pressure 120/80 mmHg. Prolonged high blood pressure above 130/80-139/89 mmHg can put extra strain on the arteries and heart. If prolonged, it will strain and weaken the arteries making it thick and inflexible and more likely to become narrowed/clogged. Severe clogs may lead to stroke, heart attack, kidney disease or even dementia." - "Healthy and unhealthy blood pressure ranges. [slide from the American Heart Association that shows different phases of high blood pressure ,and includes "Hypertensive Crisis (consult your doctor immediately)." Systolic mmHg higher than 180 and/or Diastolic higher than 120]. - "Reportable Daily Observations" slide included, but not limited to "Changes in heart rate, fast, slow, chest pain, irregular [heart symbol inserted here]." The training did not include education on low BP, or hypotension and did not include reportable criteria for high or low BP. Very low blood pressure (hypotension) occurs when blood pressure is less than 90/60 mmHg. Low blood pressure usually is not harmful unless there are other symptoms such as dizziness, nausea, fainting, fatigue, heart palpitations (American Heart Association website last reviewed 05/17/24.) 2) On 02/10/25, the State Agency (SA) received a report from the facility that C1 had a change of condition on 02/09/25 and was transferred to the Emergency Room (ER) and subsequently admitted with a diagnosis of severe sepsis (serious condition in which body responds to an infection. Symptoms include drop in blood pressure and sleepiness) due to Urinary Tract Infection and slight pneumonia. The	W0342		

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W0342	Continued from page 4 report included: "At approx. [approximately] 0600, Nurse Manager [NM] and Home Manager [HM] notified contacted Writer regarding...[C1's] ...change of condition. Per staff, vital signs were as followed [sic]: BP [blood pressure] 122/57 mmHg. [millimeter of mercury] RR [respiration rate] 21 rpm [respirations per minute]. HR [heart rate/pulse] 141 [normal 60-100]. Temp [temperature] 97.3 degrees F [Fahrenheit]. O2 [oxygen level in blood] 60-87% [normal 95-100%]. Nurse Manager informed and advised staff to call 911..." C1 is a 49-year-old female who resides in an intermediate care facility for individuals with intellectual disabilities. At baseline, she is alert and oriented to self, ambulatory and can carry a conversation. She has a history of chronic kidney disease (CKD), intermittent explosive disorder, kidney transplant, unspecified delay in development, hypertension and intellectual disability. C1 had a suprapubic catheter that drains urine from her bladder through a small incision in her abdomen. On 02/06/25, there was a medication error and C1 was given another client's medication and had an adverse reaction that included hypotension and decreased level of consciousness. At that time, she was sent to the ER for evaluation, treated and discharged back to the facility that same day. On 02/09/25, C1 had a change of condition, was taken to hospital and admitted for sepsis due to urinary tract infection and slight pneumonia. Reviewed C1's vital signs report which included the following entries: 02/07/25 at 06:45 AM: Pulse (P) 121, BP 134/62 02/07/25 at 02:41 PM: P105, Oxygen Saturation (%) 98, No BP. 02/08/25 at 05:46 AM: P132, BP 95/68 02/09/25 at 06:21 AM: P134 BP 122/52. Reviewed C1's health notes entered by DSPs which included the following:	W0342		

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W0342	Continued from page 5 02/07/25 at 01:55 PM: C1 "...arrived to ...safely. She appeared sleepy. Redirection given to wake up and start on her programs. ...[C1] ...stated that she was not feeling well and forced herself to vomit. She was crying and yelling when she threw up. ...RN was notified and Oximeter (oxygen saturation level/O2) was taken. ..." 02/07/25 at 10:51 PM: C1"...came home safe from day program. ...She's not as alert as usual. ..." 02/08/25 at 08:43 PM: C1"...verbalized "not feeling well" when i [sic] started my shift. I noticed she had runny nose and productive cough. inform the manager and nurse. As per nurse instruction, we'll give her PRN [as needed] meds [medications] for cough every 8 hrs [hours]. ..." 02/09/25 at 07:27 AM: C1 "...was doing fine throughout the night she wake up but very sleepy." Although it was not documented, the nurse was notified at approximately 06:00 AM on 02/09/25, and staff reported a change of condition and C1 was transferred to the ER by 911. There was no evidence to support the DSP reported C1's tachycardia (rapid heart rate) to the RN the AM (morning) shifts of 02/07/25 and 02/08/25. The tachycardia accompanied with the observed documentation that she was more tired than usual should be reported to the RN and may be early indicators of an evolving condition change that requires more monitoring. On 03/11/25 at approximately 10:00 AM, interviewed DSP2, who worked the night shift and documented the early AM vital signs on 02/07/25 and 02/08/25, when C1 had tachycardia. DSP2 confirmed she worked those nights and that she recorded the vitals prior to going off shift. She was aware that C1 went to the hospital the morning of 02/09/25. Asked DSP2 if she recalled C1's pulse being rapid the day before on 02/08/25, and she said she did. She went on to say she reported it to the oncoming shift and asked them to "monitor her." DSP2 confirmed she did not notify the RN of the rapid heart rate. She said she did not recall anything unusual on 02/07/25. On 03/11/25 at 12:45 PM, interviewed the NM in the training room. At that time, discussed the training	W0342		

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W0342	Continued from page 6 for the DSPs for detecting signs and symptoms of illness, injury or change in client's health care baseline. She said the training is done annually. The NM acknowledged the training included observations the DSP are to report to the Nurse, and the only vital signs included were "Changes in heart rate, fast, slow, irregular." She said the DSP is expected to know abnormal vitals. Discussed C1's baseline and the NM said she does run a low blood pressure at times due to her kidney disease. The NM said there was not a written facility policy/procedure for change of condition or when to notify the nurse, and that they use the power point and educational material as that reference and procedure.	W0342		
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. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure all medications were administered in compliance with physician orders for one of one client (Client (C) 1) sampled for medication administration at adult day health (ADH). As a result, C1 received the wrong medications, had low blood pressure, and was sent to the emergency room (ER). Findings include: C1's current diagnoses include, severe intellectual disability, mood instability with paranoia, chronic kidney disease (had a kidney transplant in 2008), insomnia, stasis dermatitis, hypertension, hip dysplasia (had a hip replacement in 2015), incontinence with suprapubic catheter, and schizoaffective disorder. C1 has several medication allergies that include, Keflex, clindamycin metoprolol, Procardia, Bactrim, famotidine, atorvastatin, and aspirin. On 02/10/25 the facility reported medication error incident to the Survey Agency (SA) documenting on 02/06/25 while out in the community during the ADH program at approximately 11:15 AM, Direct Support Professional (DSP) 1 administered C1 another client's medication, Tizanidine (muscle relaxant) 4 milligrams (mg.) and metformin (to treat	W0368		

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W0368	Continued from page 7 high blood sugar levels for diagnosis of diabetes mellitus) 500 mg., instead of magnesium oxide (to relieve heartburn or acid reflux) 400 mg. and phospha (to increase the amount of phosphate in the blood) 250 neutral tablet (tab.). Nurse Manger (NM) was immediately notified, and staff were instructed to ensure C1 eats, monitor for side effects, and return to ADH as soon as possible. At approximately 12:30 PM, C1 returned to ADH and Nurse Case Manager (NCM) assessed C1. Upon assessment, C1 was " ...observed to be slightly slouched in her wheelchair and appeared to be in deep sleep .... attempted to arouse ...[C1] ...by calling her name and rubbing her shoulders. When no response obtained .... performed sternal rub and vital signs. Vital signs were as followed: BP [blood pressure] 75/53 mmHG [millimeters of mercury] (1st read) and 79/56 (2nd read). HR [heart rate] 65 bpm [beat per minute]. RR [respiratory rate] 20 RPM [breaths per minute]. Temp. [temperature] 97.0 degrees F [Fahrenheit]. O2 [oxygen] 98%. Client awakened for a few minutes and verbalized dizziness before returning back to sleep. Client experienced intermittent periods of sleep through the duration of events. Mental status altered and stuporous." After NCM performed her assessment, she reported findings to NM and agreed medication attention was necessary, the emergency service was notified of C1's hypotensive status and was sent to the ER by ambulance. Review of C1's physician orders documented C1 did not have an order for metformin or tizanidine. C1 had an order for phospha 250 tab. Neutral, take two tabs. by mouth with lunch at 11:00 AM and magnesium oxide 400 mg tabs/ take one tab. by mouth three times daily at 12:00 PM. On 03/10/25 at 10:51 AM, an interview with Nurse Manager (NM) was done. NM reported medications errors such as administering the wrong medication to someone else puts clients at risk of death. On 03/11/25 at 09:57 AM, an interview with DSP3 was done. DSP3 reported on 02/06/25, that DSP3, DSP1, and C1 were in the facility van when C1 was administered the medications. DSP3 handed DSP1 the bag (backpack) with client medications. The bag had three clients' medications with their folder in the bag. Usually, the medications are in the folder to separate the client medications but on this day the medications were out of the client folders in the bag. After DSP1 administered medications to C1, DSP3 went in the bag to retrieve her assigned client's	W0368		

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W0368	Continued from page 8 medication but noticed they were signed off and administered. DSP3 notified DSP1 of the error and it was discovered DSP1 gave C1 another client's medication. DSP3 did not observe DSP1 review the rights of medications prior to administering the medications. DSP3 stated during administration the rights of medication should be done and the orders should be reviewed prior to administration. On 03/11/25 at 10:00 AM, an interview with DSP1 was done. DSP1's recollection of the incident slightly varied from DSP3's. DSP1 confirmed on 02/06/25 while in the community, she made an error and gave C1 two medications that were meant for someone else. She said they usually have three to five clients that need medications while they are out in the community. DSP1 explained one DSP will get the medications for all the clients from the locked cabinet in the office and put them in a bag that locks, which they take with them. She said that day, they were at the district state park and the clients were ready to eat lunch and needed their medications. DSP1 said when they are in the community, they prepare the medications in the van. She said the lead DSP (DSP3) was with her that day, so "since there were two of us, I asked DSP3 who was at the bag, for C1's meds [medications], and she handed me the blister pack that was in a Ziplock bag. DSP1 further stated, "I did not do my five rights for medication administration, and just gave them to her without checking to make sure they were the right meds." Asked if the Client's names are on the Ziplock bag, and she said she didn't think so, but it is on the medication itself. DSP1 said she usually uses her phone to access the medication administration records while in the community but didn't do it that day. On 03/11/25 at 10:20 AM an interview with NCM was done. NCM confirmed C1 was administered another client's medication on 02/06/25 and C1 did not have an order for those medications at all. NCM confirmed her assessment of C1, difficult to arouse and hypotensive, C1 was sent on an ambulance to the emergency room. Review of the facility's training material for medication administration include training on "How to prevent Medication Error? Follow the 6 Rights!" The 6 Rights of Medication Administration include 1) Right Client, 2) Right Medication, 3) Right Dose, 4) Right Time, 5) Right Route, and 6) Right Documentation.	W0368		