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 09/26/2025

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
E0000	Initial Comments A focused fundamental recertification survey was conducted by the Office of Healthcare Assurance from September 24, 2025, to September 26, 2025. The facility met the health requirements for 42 CFR 483.475 of Appendix Z, Emergency Preparedness for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).	E0000		
W0000	INITIAL COMMENTS A focused fundamental recertification survey was conducted by the office of healthcare assurance on September 26, 2025. The facility was found not in compliance with 42 CFR 440.150. survey dates 09/24/25 to 09/26/25. Census: Five Clients. Sample: Three clients.	W0000		
W0263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is NOT MET as evidenced by: Based on interviews and record review, the agency's human rights committee did not ensure that written informed consent was obtained for an anti-psychotic medication for one of three Clients (C) 1 in the sample. This deficient practice prohibited C1's representative from being fully informed of the risk and benefit of the medication. Findings Include:	W0263		

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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W0263	Continued from page 1 Record review on 09/25/25 at 01:00 PM indicated that C1 had a behavior plan and was prescribed Aripiprazole (an anti-psychotic medication used to decrease aggressive behavior) 2 milligrams (mg) orally every morning. There was no written, informed consent for the use of the medication obtained prior to administration of the medication to C1. Interview with the Nurse Manager (NM) on 09/25/25 at 01:30 PM acknowledged that a written, informed consent was not obtained and was missed. Interview with the Intermediate Care Facility Program Manager (ICFPM) on 09/26/25 at 11:30 AM concurred that a written consent for psychotropic med should have been obtained prior to the administration of medication. The facility's "Policy and Procedure for Obtaining Consents for Psychotropic Medication," dated 2025 reviewed on 09/26/25. In the "Policy" section, it states "Written consents shall be obtained for psychotropic medication (antipsychotic, antidepressants and antianxiety medications) prior to their use ..."	W0263		
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 interviews and record review, the facility failed to schedule a follow-up appointment for one of three clients (C) 1 sampled for health screening. This deficient practice potentially placed C1 at risk for illness. Findings Include: C1 is a 26-year-old female who was admitted to the facility on 10/24/24 with a diagnosis that includes but is not limited to moderate intellectual developmental disability, amenorrhea (an abnormal menstrual cycle), and bicornate uterus (a congenital condition characterized by a heart-shaped uterus that has two cavities instead of one).	W0322		

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W0322	Continued from page 2 On 09/25/25 at 01:30 PM, a record review C1's specialty appointments revealed that she had an appointment on 02/10/25 with a gynecologist for amenorrhea and a pap smear exam to screen for cervical cancer. The pap smear was unsuccessful due to C1's discomfort and vaginal irritation due to her low estrogen levels. C1 was prescribed a vaginal cream for local application to improve comfort. A follow up pap smear was to be reattempted later. A review of the quarterly assessment team meeting and nursing progress report's for July-August 2025, revealed there wasn't a follow up appointment made for a pap smear. Interview with the Nursing Manager (NM) on 09/26/25 at 09:30 AM validated that a follow up appointment wasn't made and should have been scheduled, as it is part of C1's health screening. Interview with Intermediate Care Facility Program Manager (ICFPM) on 09/26/25 at 11:30 AM confirmed that a pap smear is part of C1's preventative health screening and should have been made.	W0322		
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 observations, interviews, and review of the facility's policy, the facility failed to store perishable food items in the refrigerator at the proper temperature to prevent spoilage. This deficient practice placed the clients residing in the home at risk for foodborne illness. Findings Include: On 09/24/25 at 12:00 PM, an initial walkthrough of the kitchen with the House Manager (HM) was completed. The refrigerator temperature log from 09/1/25 to 09/24/25 recorded 40 degrees (°) Fahrenheit (F). Observation of the internal refrigerator thermometer read 66° F. Concurrent	W0454		

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W0454	Continued from page 3 interview with the HM noted that one of the Clients (C) 1 had been going in and out of the refrigerator to get her drink, which caused the temperature to read higher than the acceptable range. The HM verbalized that the refrigerator temperature checks are done by the night shift staff early every morning. On 09/25/25 at 05:45 AM, observed refrigerator thermometer temperature at 52°F. The Direct Support Professional (DSP) said the temperature was up due to staff opening the refrigerator in preparation for breakfast. The DSP also said she was not able to record the temperature reading on the log that morning. Observations were made between 05:45 AM to 07:00 AM. The refrigerator was unopened and by staff or the Client's. A recheck of the refrigerator thermometer at 07:05 AM read 60° F. The HM agreed that the thermometer was not working properly and would need to be replaced in order to store perishable items at the proper temperature to prevent food spoilage. The facility's "Policy and Procedure for Food Safety and Handling", revised 2024 was reviewed on 09/26/25. In the "Purpose" section, it notes, "To prevent spoilage and preserve nutritive value of food served to the residents ..." In the "Thawing/Defrosting" section, it notes, "Refrigerator should be at 40 degrees ...temperature log should be kept at the door and temperature logged daily. Report to maintenance if temperature is always out of norm."	W0454		