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 12/15/2023

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 recertification survey was conducted by the State Agency (SA) from 12/13/2023 through 12/15/2023. 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 recertification survey was conducted by the State Agency (SA) from 12/13/23 through 12/15/23. 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). Census: Four clients Sample size: Two clients	W0000		
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of two clients sampled received a continuous active treatment program consisting of needed interventions in sufficient frequency to be included and supported in the individuals' program plan (IPP). As evidence by, failed to ensure Client (C) 1's Velcro strap	W0249		

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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W0249	Continued from page 1 intervention was developed and included in C1's IPP; failed to ensure C2's IPP was implemented by emptying C2's catheter bag every two to three hours. Findings include: 1) On 12/13/23 from 02:24 PM to 05:28 PM observed C1 in the home with a Velcro chest strap around his chest while in his wheelchair. Staff members in the home did not remove C1 from his wheelchair or the Velcro chest strap during the observation period. During further observation on 12/14/23 from 05:26 AM to 06:56 AM, observed C1 in the home with a Velcro chest strap around his chest while in his wheelchair. On 12/14/23 at 06:41 AM interview with Home Manager (HM) was done. HM stated C1's Velcro chest strap is never released while C1 is in his wheelchair. Observation on 12/13/23 and 12/14/23 at the Adult Day Program, observed C1's Velcro chest strap released while in his wheelchair. Review of C1's current IPP, physician's order, and Human Rights Review did not include parameters for the Velcro chest strap. On 12/15/23 at 10:49 PM interview with Registered Nurse (RN) 1 was done. RN1 reported staff members should be releasing C1 from the Velcro chest strap every two hours. RN1 confirmed the parameters were not included in the IPP. 2) Interview was conducted on 12/13/23 at 12:00 PM with Direct Support Professional (DSP) 1. DSP1 stated that the clients are at the program six hours a day. Concurrent observation and interview were conducted on 12/13/23 at 01:00 PM in the women's bathroom. DSP1 was observed emptying C2's urinary catheter. When queried on how often C2's urinary catheter was emptied at the day program,	W0249		

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W0249	Continued from page 2 DSP1 stated that it is emptied once a day. Interview was conducted with DSP2 on 12/14/23 at 01:18 PM in the day program classroom. When queried about the emptying of C2's urinary catheter, DSP2 stated that C2's urinary catheter is emptied once a day between the times of 12:00 PM to 01:00 PM. A review of C2's Electronic Health Record (EHR) was conducted on 12/15/23. C2's EHR indicated that between the dates of 11/27/23 to 12/14/23, C2's urinary catheter was emptied twice during program hours on three different days. The other eleven days indicated that it was only emptied once during the day program. A review of C2's document titled, "ICF/IID-C Individual Program Plan (IPP)," with a conference date of 09/19/23 was conducted on 12/14/23. The document indicated, " ...has a supra-pubic catheter in her left pubic area and requires that staff monitor her bag and empty it every 2-3 hours ..." Interview was conducted on 12/15 23 at 10:59 AM with Registered Nurse (RN) 1. RN1 stated that C2's urinary catheter should be emptied around every 2 hours. RN1 also added that the staff at the day program and at home should be looking at the urinary catheter to monitor urine output. Staff was instructed by RN1 to notify her for decrease urine output.	W0249		