STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC OF MAUI - HALE KIHEI	179 HALE KAI STREET 140 N MARKET ST, SUITE 202B, WAILUKU, HI 96793, KIHEI, Hawaii, 96753

(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 A federal abbreviated complaint (ACTS # 10223) survey was conducted by the Office of Health Care Assurance on 05/24/2023 through 05/26/2023. The facility was found not to be in substantial compliance with the requirements of 42 CFR 440.150, Subpart I, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), with Non Condition citations.	W0000		
W0125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is NOT MET as evidenced by: The guardians of one Client (C)1, made the agency aware they had concerns about the investigation related to an incident on April 7, 2023 when C1 sustained a large head laceration of unknown origin. Concerns were expressed that it may not have been an accident or fall, but rather a potential abuse/neglect. There were two responses after the incident from the agency to the guardian, that were not appropriate and generated what the guardian felt was the appearance of retaliation to the guardian and C1. The grievance is not closed due to ongoing investigations from external agencies. Findings include: 1) C1 is a 31 year old male who has a complicated medical history that includes profound intellectual disability, Autism, Pulmonary Fibrosis, Corpus callosum (brain disorder caused during fetal development, coffin siris syndrome (affects several body systems, hallmark condition is developmental disabilities), and global developmental delays	W0125		

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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W0125	Continued from page 1 (significant delays in cognitive and physical development). He has lived at the residential (intermediate care/ICF) facility since April of 2019. His parents are actively involved in his care and frequently take him home for visits. On 04/07/2023, C1 sustained a large head laceration and the mechanism of injury was unknown. 2) During an interview with C1's guardian (G)1, she said they are a religious family, and shared she posted something on her personal facebook page asking for prayers for her son from family, friends, and religious communities after her son's injury. She said the post did not identify the agency, or any staff. G1 went on to say, after the posting, she had a phone conversation with the CEO (Chief Executive), who was very upset with her about the facebook posting. G1 offered the CEO a copy, but said she refused. G1 reiterated there were no identifiers in the posting, or accusations. G1 said, "The CEO did not understand that as a private citizen Mother was within her constitutional rights to practice and follow cultural and spiritual practices for her son from faith and healing communities." On 05/26/2023 at 10:20 AM, during an interview with the CEO, she said she usually is not involved to this extent. She said her first contact with the guardians was when G1 called her on 04/12/2023, requesting copies of the incident report. The CEO said spoke with G1 several other times. The CEO said she did discuss the facebook posting with G1 and felt the agency and staff were "being called out," but knew it was G1's right to post to her personal facebook. Inquired if there had been a face to face meeting, to discuss their concerns, she replied no. 3) Due to the guardians concerns, there was a request made to the CEO and Program Director (PC), that C1 be transferred to another group home. During an interview with the guardian, she stated the request was denied, and the response given by Administration staff was, "the guardians can take their son home, if they don't like it at the current house." She went on to say the agency CEO and Program Director did not directly communicate with them, but relayed the message about their decision through another individual from an external agency, who was involved in the case. She said she was not provided any details why the transfer was denied.	W0125		

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W0125	Continued from page 2 On 05/26/2023 at 09:45 AM, during an interview with the PD, she said she first became aware the guardians were upset when someone notified her of the facebook posting, and multiple agencies began contacting them. The PD was aware of the request to transfer C1, but said the agency did not feel it was in his best interest. She went on to say there were some staffing issues at one facility and the clients behaviors at the other house would not be the best match for C1. The PD said she received a voicemail from C1's father which said they may contact the ombudsman and OCHA (Office of Healthcare Assurance), but she did not return the call. She said she had not met with the guardians or personally talked to them.	W0125		
W0154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is NOT MET as evidenced by: Based on interviews and document review, the agency failed to identify an injury of unknown origin as a possible abuse/neglect, after one client (C)1 sustained a large head laceration. In addition, the agency failed to conduct a thorough investigation. Specifically, the investigation did not include adequate collection of interviews, statements, physical evidence/diagrams, resolution of discrepancies or written recommendations after the investigation. This deficient practice, puts clients at increased risk of abuse/neglect if thorough investigations are not done. Findings include: 1) The Office Health Care Assurance (OHCA) received one facility reported incident (FRI), ACTS # 10223, completed by the House Manager (HM) on 04/13/2023. The report was marked as both initial and completed report. The type of incident was documented as "Unknown Injury." Details of the incident included: "On Friday afternoon 04/07/2023 at around 1:39 PM, DSP- (Direct Support Professional) staff DSP1 notified house manager (HM) that C1 had an	W0154		

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W0154	Continued from page 3 unwitnessed fall and received a cut approximately (2 inches) in length on the top (Right) side of his forehead. The cut was an open wound that started to bleed. Staff treated C1 with first aid and showered him. Staff then notified the agency nurse (RN2). The agency nurse stated that he received a call from DSP1 that C1 had an unwitnessed fall and was found on the floor near another client's room. DSP1 stated that C1 had a cut to his head due to the fall. Staff were informed to take him to the ER (Emergency Room). I (RN1) met staff at the ER and escorted C1 into triage. C1 had imaging to his right foot and CTs (cat scans) to his head and c-spine (cervical spine), all three scans were negative. Six staples were placed and a bandage was applied. .... HM, spoke with C1's parents/guardians and explained to them it was possible that he fell in his bedroom. The house manager felt his bedroom was too cluttered up with too much furniture brought from his parent's house and that it was possibly hazardous for his mobility around his bedroom. The parents agreed to come... The bedroom now has lots of open space for C1 to walk around safely in his bedroom." 2) C1 is a 31 year old male who has a complicated medical history that includes profound intellectual disability, Autism, Pulmonary Fibrosis, Corpus callosum (brain disorder caused during fetal development, coffin siris syndrome (affects several body systems, hallmark condition is developmental disabilities), and global developmental delays (significant delays in cognitive and physical development). C1 is usually is able to understand, but his communication is very limited and not clear to everyone. The staff said over the years they have learned to understand him when he expresses himself with gestures and a few words. C1 did not have a history of falls and did not require assistance for mobility. He has resided in the small community based residential (intermediate care/ICF) facility since April of 2019. His parents are actively involved in his care and frequently take him home for visits. The ICF house services five clients and is staffed with one full-time and one part-time house manager (HM). The HM at this facility is also the Case Manager who has responsibility for overall supervision with support services of Social Worker, RN's and DSP's. 3) Reviewed facility documents related to the incident and investigation:	W0154		

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W0154	Continued from page 4 "Amended 1147i (dated 4/12/23) for C1's incident dated 4/13/23," prepared by Program Director (PD) included: -"The agency nurse notified in this incident was RN1, not RN2." -"It is unknown how the injury occurred. It was not witnessed as stated. C1 was returning from a community activity with the other 4 clients and 3 staff. Two staff entered the house with C1. C1 assisted one of the staff into the kitchen with a bag, which he enjoys doing, and the other staff had to use the bathroom. The third staff stayed in the van with the clients. The staff that had accompanied C1 into the house went back out to the van to assist with unloading the other clients, including two in wheelchairs. C1 must have headed toward the hallway toward his room during this time. The staff using the bathroom came out at the same time one of the other staff was coming back into the house to check where C1 was. He was found on the floor in the hallway at the opposite end of his bedroom. This all occurred within approximately a 5-minute timeframe." - "Based on the injury, the agency nurse believes it's possible this incident was caused by C1 losing his footing and hitting his head on the door jam." - "Although rearranging his room to make it more accessible may decrease the likelihood of a future issue, it is likely this had no relation to this accident and there is no one to blame." - "4/10/2023 (correct date was 4/11/2023)-C1 was seen by his PCP (primary care physician), for follow-up. ..." "Manager/Case Manager (HM) Comments: (Incident Report on C1-3/30/23[sic])" (signed and dated 04/14/2023): "... I spoke to each staff person (DSP1, DSP2, and DSP3) which none could stated [sic] what happened due to not witnessing the incident. What was explained to me, HM that the staff and clients just returned home from an outing around (1:00 p.m.) and that DSP1 came into the house right away to use the restroom. While she was in the restroom DSP2 stated that she assisted C1 into the house as	W0154		

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W0154	Continued from page 5 he was carrying bag to bring in to the house. After he set the bag down DSP2 stated that C1 went and sat down in the living room on the floor or couch, she said she could not remember. Then DSP2 went back to the van to assist DSP3 unloading the wheelchair clients. While assisting DSP3 at the van, a few minutes later, DSP1 approached DPS2 and instructed her to go and check on C1, to see where he was. When DSP2 went to find C1 she found him standing by the wall in the hallway across from (R2's) bedroom with blood coming out of his head. DSP2 called for help to assist with C1 incident. Based on statements of the staff this incident does not appear to be the result of any neglect or abuse by staff. It is unfortunate that it happened but was the nature of an unwitnessed incident." "Reporting Form" completed by DSP2, dated 04/07/2023: "...I assisted C1 carried the bags w(with)/the staff, beside him, to get inside the house. Since DSP1 was inside the house, it means one staff watch the clients. So since C1 is safe around at the day area w(with)/out behavior. I went back to unload my other client. While lifting the conveyor, DSP1 came to me, she told me check C1. So I never finished to close the conveyor, I came inside the house right away. I was shocked that C1 was sitting down at the hallway before C2's room. C1 was covered plenty blood of his face & his body & plenty blood at the floor. I checked where the blood from, there's a cut at his right upper forehead. Probably 2 inches cut. DSP3 and DSP2 helped me to clean the floor & his body. Give him first aid and notified the House Manager." The report was signed by the HM, Program Director (PD), and RN1 on 04/10/2023. 3) Reviewed the agency policy titled "Abuse/Neglect Investigation," which included the following: -Policy statement: "It is the policy of ... that all employees comply with the State of Hawaii Revised Statutes (HRS) chapter 346 regarding Adult Protective Services and investigate all allegations of abuse, observed abuse, neglect and injuries of unknown origin. The primary intent of the law is to protect elders who are mentally and physically impaired, as this group is most vulnerable to abuse and neglect. ..."	W0154		

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W0154	Continued from page 6 - Procedure: "Investigations will be done by an Investigative Team which will include a Case Manager/QMRP and a Registered Nurse." - "1. The Investigative team member notified will assess for implementing immediate action to protect the victim and any other clients and this action will be documented on the Investigative Report." - "2. The Investigative Team will interview the victim/alleged victim unless the victim is unable to communicate (nonverbal). The Investigator will ask the client how the injury happened, when it happened, where it happened, who was present (staff, visitors, and other clients), and if they have any need or request as a result of the incident. The client will be monitored for signs of aversive reactions which can include avoidance of another person or object, withdrawn behavior, overly compliant behavior, signs of fear (verbal or nonverbal startle response, crying, or submissive posturing). This information will be documented on the Investigative Report. 4) On 05/24/2023 at 10:35 AM, during an interview with DSP2, she confirmed she had been assigned to C1 the day of the injury. She said when they returned from the outing, DSP1 went into the house alone with C1, and she stayed to unload the other clients from the van. DSP2 went on to say a while later DSP1 came back outside and called her "Auntie, can you go check for C1?" DSP2 said she went in right away, and found C1 in the hallway sitting down with blood. She said, "What I know is that she (DSP1) was supervising him. DSP1 told me C1 was not answering when she was calling out to him." When asked if DSP1 looked around the house for C1, DSP2 said she did not know. On 05/25/2023 at 01:44 PM, during an interview with DSP1, she said when they came back from the outing, she left the van running and went into the house alone because she had to go to the bathroom. DSP1 said when she came out of the bathroom, she saw C2 in the day room, but did not see C1. She went on to say she took C2 to his room first and then to the bathroom. When she came out of the bathroom, she saw C1 in the hallway by himself. DSP1 said she proceeded to the living room area and called out for C1. She said she called for him three times and he did not answer. At that time, she said there were two other clients in the living room, so she went to the exit door and saw the other staff unloading and asked DSP2 to come look for C1, "because she had been assigned to him." DSP1 said	W0154		

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W0154	Continued from page 7 "DSP2 found C1 on the ground gushing blood." She said after everyone was in, she went back out to turn off the van. When DSP1 was asked if there had been any changes in practice or routine since the incident, she replied no. On 05/23/2023 at 02:30 PM, during an interview with HM, he explained C1 has good balance and had no falls in the past to his knowledge. HM said C1 knows how to seek assistance, and that he is not on one to one supervision and often spends time alone in his room. He went on to say C1 and C3 are the higher functioning clients in the house and sometimes they "bump heads with eachother and correct eachother," so the staff are careful to ensure supervision when around eachother and unloading the van. He said DSP2 gave C1 a bag and brought him in the house. She left to go back to the van when he was sitting on floor. At that time C1 was the only client in the house. DSP2 felt he was safe, and there should be no reason for additional precautions as he can be comfortable left alone for periods of time. HM said the injury occurred was a holiday (Friday), so he was not at the house. He went on to say when he returned on Monday he tried to get the staff to tell him what happened, but kept getting different stories, so he "sat down DSP2 and DSP3 together to go over what happened." The HM said he did not document the group interview. He said he did sit down with DSP1 individually, but did not interview her "at the same level," and did not document the interview. The HM confirmed he generated the report to OHCA, and said part of the report was completed by him, and part by the RN involved. He acknowledged C1's injury was of unknown origin, but felt it was an accident based on statements, and did not think of reporting it as a potential abuse of neglect, which required notifications to Adult Protective Services and the Police. HM said he knew C1's mother was upset because they did not have an explanation for what had happened, but first became aware that there were concerns of potential abuse/neglect when outside agencies began coming to do investigations. HM said after the incident, he informed the staff that if someone has to go to the bathroom right away, to not start unloading the clients until everyone is present. He also said although there was no documentation of follow up, he reminded the staff that just because a client is assigned to a specific staff, everyone is responsible for the supervision.	W0154		

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W0154	Continued from page 8 The HM said he was not aware the agency had a detailed policy, "Abuse/Neglect Investigation," that provides guidelines for conducting and documenting an investigation. On 05/23/2023, both RN's were interviewed and said they were not involved in the investigation, or review of the incident, and were unaware the agency policy that had "investigation team," for an injury of unknown origin, that included the RN. 5) Although there was not sufficient evidence that there was abuse, or neglect, there remained discrepancies in the reports as well as the interviews, which had not been further investigated for resolution.	W0154		
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: The agency was unable to provide transportation services for one client's (C)1 scheduled appointment with his primary care physician (PCP) on 04/11/2023 after he had an Emergency Room visit on 04/07/2023. As a result of this deficiency, C1's father was asked to transport him to receive the necessary care for follow up. If there is not a clear process for scheduling appointments, there is potential clients will not get the necessary medical care they need. Findings include: 1) C1 is a developmentally delayed 31 year old male who resided in the small community based residential (intermediate care) facility. On 04/07/2023, he had a closed head injury of unknown origin which resulted in a right (R) scalp laceration, approximately 5-7 cm (centimeters) in length, and swelling of his right ankle. He was treated at the Emergency Room where he received six staples to close the wound. The first follow up appointment after the injury was made by the agency with C1's PCP for 04/11/2023 at 08:15 AM.	W0322		

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W0322	Continued from page 9 2) Reviewed the agency document titled "Services Provided by the ICF (Intermediate Care Facility) Program, which included the following: "E. Residential Facility Services ... the residential facility staff will be responsible for following up on all required/prescribed medical care services (e.g. take clients to the medical appointments.) ..." " G. Transportation ...The residential facility staff will be responsible for all other transportation services (e.g. between home and doctor's office." 3) On 05/25/2023 at 09:10 AM, interviewed Registered Nurse (RN)1, who went to the ER with C1. She said the agency staff make the follow up appointments and transport the clients to and from the doctors office. On 05/25/2023 at 09:30 AM, during an interview with RN2, he said the agency makes the arrangements for doctors appointments. RN2 said he took C1 to the appointment on 05/14/2023 to have the staples removed, but C1's dad took him to the first appointment because they were booked with other appointments. On 05/25/2023 at 02:30 PM, during an interview with the House Manager (HM), inquired why the agency did not transport C1 to the follow up visit on 04/11/2023. He confirmed C1's father took him to that appointment and said the agency was not able to provide staff for the transportation because the appointment was made earlier in the day than usual. The HM said they do not have written guidelines or a policy for scheduling appointments.	W0322		
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.	W0342		

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W0342	Continued from page 10 This STANDARD is NOT MET as evidenced by: Based on interviews, and document review, the agency did not demonstrate competency when they responded to a client's (C)1 injury of unknown origin, that resulted in a large head laceration on 04/07/2023. The staff failed to provide the standard of care for appropriate first aid, which would be to apply pressure and call 911, or nursing staff prior to moving him. In addition, the staff showered C1 prior to contacting the Registered Nurse (RN)1. If staff are not competent to deliver appropriate first aid measures, it puts any client with an illness or injury at risk for further harm. Findings include: 1) On 04/12/2023, the Office of Healthcare Assurance received a facility reported incident (FRI) from the agency that C1 had an injury of unknown origin on 04/07/2023. Details of the Incident included: "...DSP- (Direct Support Professional) staff DSP1 notified house manager (HM) that C1 had an unwitnessed fall and received a cut approximately (2 inches) in length on the top (Right) side of his forehead. The cut was an open wound that started to bleed. Staff treated C1 with first aid and showered him. Staff then notified the agency nurse (RN). ...Staff were informed to take him to the ER." C1 was transported to the ER, by private car with agency staff. 2) Review of the Emergency Room Provider Notes dated 04/07/2023 included: - C1 was "placed in C-collar on arrival as precaution. Caregiver doesn't know what he hit his head on or if he lost consciousness. ...HPI (history of present illness) is limited because patient is nonverbal. Right ankle is also swollen." - "Differential Diagnosis (involves making a list of possible conditions that could be causing your symptoms): ...Fall, syncope, intracranial injury, spinal injury, intrathoracic or intrabdominal injury, occult infection (such as UTI (urinary tract infection), pneumonia, dehydration, electrolyte disturbance, extremity fracture, MI (heart attack) or ACS (acute coronary syndrome), CVA (stroke), TIA (transient ischemic attack) or other intracranial pathology"	W0342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G036	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W0342	Continued from page 11 -"Medical Decision Making: ...A Head CT was ordered based on the following indications(s): Dangerous mechanism of injury (include details of MOI (mechanism of injury). Patient had an unwitnessed fall with headstirke and it is unknown if he lost consciousness. ..." 3) Reviewed the agency "ICF/ID Staff Training Manual," which included copies of training materials tabbed by topic. One of the sections was "Health/Medical." This section included, but not limited to application of ice, what to do if a client has a temperature, and what to do if someone has a seizure. The content was limited, and did not contain first aid for falls, burns, head injuries or lacerations. 4) On 05/25/2023, during an interview with the Program Director, she said all staff have first aid training on hire and also are required to take a CPR/First Aid course (National Health & Safety Association 2020) on line. They get a certificate after completion and are required to take it every two years. Reviewed the content listed in the "Standard CPR/AED & First Aid Course Curriculum," which included: Cardiovascular disease, Heart attack, Stroke, Rescue breathing, CPR, AED, Bites, Stings, & Poison, Allergies, Asthma, Heat & Cold Emergencies, Opioid Overdose, Choking, Bleeding control, Shock, Moving People, Head, Neck, & Back Injuries, Burns, Eye Injuries, Diabetes, Seizures and Drowning. 5) On 05/25/2023 at 01:40 PM, during an interview with DSP1, she said she assisted DSP3 with C1, in the bathroom after the injury. Inquired what first aid was provided when C1 was found on the floor bleeding. DSP1 said, "He (C1) had so much blood that day, we had him to sit him on the toilet first and put pressure to stop the bleeding, then had him enter the shower." DSP1 said she was the one who contacted RN1, who asked how serious the injury was, and she said, "... he needs to go to the ER. ..." On 05/25/2023 at 09:10 AM, during an interview with RN1 asked how she would expect staff to respond if they found someone on the floor with a large head laceration. She replied, "Apply pressure and notify the nursing staff." When asked if that was	W0342		

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W0342	Continued from page 12 what the staff did, she said "I'm assuming." Shared with RN1 the moved C1, showered him due to the large amount of blood, before calling the her. RN1 replied, "I don't know why they did that, he had a large laceration." On 05/25/2023 at 09:30 AM, during an interview with RN2, the full-time RN, he said he found out about C1's injury about an hour after it happened. He said the staff had called, but he did not get the message right away, and when he called back, RN1 had already responded. RN2 said the staff text him a picture of C1's wound. Inquired how the staff would be expected to respond to a head injury with large laceration with unknown mechanism of injury. RN2 said, "Not move him if found down. Call 911, or notify nursing for further instruction." RN2 went on to say the staff at the house are not medically trained, and don't have that critical thinking piece and probably thought they should clean the wound. RN2 said he just started at the agency six months ago, and did not know the specifics of the online first aid training or how involved it was. He went on to say this incident made him realize he needed to do additional training and restructure the program, "Definitely more training about when not to move someone."	W0342		