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 10/27/2023

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
E0000	Initial Comments A recertification survey was conducted by the Office of Health Care Assurance on 10/27/23. The facility was found to be in substantial compliance with the requirements for Emergency Preparedness, §483.475 (Appendix Z).	E0000		
W0000	INITIAL COMMENTS On 10/27/23 a recertification survey was conducted by the Office of Health Care Assurance. A focused fundamental fundamental survey found the facility was not in substantial compliance with requirements at 42 CFR §483, Subpart I. The census was five clients. Three clients were selected for the core sample with additional two sample clients.	W0000		
W0130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is NOT MET as evidenced by: Based on observation, the facility did not assure privacy was provided during personal care for 1 of 3 clients in the core sample. Findings include: On 10/25/23 at 02:30 PM, the door to Client (C)2's room was open. Observed C2 lying in bed wearing a t-shirt and personal brief. Direct Care Staff (DCS)3 confirmed that she would be changing the client's personal brief. Observed C5 ambulating in the hall and stood by the wall close to C2's room (hall exit with curtains). A staff member commented to C5, what are you doing and prompted C5 to return to the living room.	W0130		

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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W0130	Continued from page 1 During care, the door was left open, staff member was heard telling C2 what she was doing throughout the brief change. Upon approach to the door, C2 was observed from the hallway lying in bed with personal brief exposed. DCS3 then put C2's shorts on.	W0130		
W0190	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' developmental, This STANDARD is NOT MET as evidenced by: Based on observation and interview with staff members, the facility did not assure staff demonstrated competency to safely transfer Client (C)2 from bed to wheelchair. The wheelchair brakes were not engaged during the transfer resulting in potential for the client to fall if the wheelchair slipped out from under him. Findings include: On 10/25/23 at 02:30 PM, Direct Care Staff (DCS)3 completed peri-care for Client (C)2 and called for assistance to transfer the client from the bed to the wheelchair. The wheelchair was placed close to the bed, C2 was assisted to sit up in bed. DCS1 entered the room to assist. C2 was manually lifted by staff from bed to the wheelchair. The wheelchair was observed to swivel during the transfer. While applying the footrests, the wheelchair continued to move. Observed the wheelchair brakes were not engaged. On 10/26/23 at 01:15 PM, observed a mechanical lift in C2's room. Interviewed DCS2 regarding the use of the lift. DCS2 reported staff have been trained and approved to do two-person transfer. DCS2 confirmed the wheelchair brakes should be engaged during the transfer and positioning of the client. On 10/27/23 at 08:50 AM an interview was conducted with Registered Nurse (RN). Inquired whether C2 requires the use of a mechanical lift for transfers. RN responded staff may use the mechanical lift or two-person transfer. Further	W0190		

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W0190	Continued from page 2 queried whether the brakes of the wheelchair should be engaged during the transfer. RN replied brakes should be locked for safety as the wheelchair can roll out from under the client.	W0190		
W0371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is NOT MET as evidenced by: Based on observations and record reviews, the facility did not assure clients' Medication Self-Administration Program was implemented. Also, staff inconsistently implemented the clients' medication self-administration program, one staff member performed majority of the tasks while another staff member, provided opportunities for clients to complete tasks of self-administration of medication and created opportunities for choices, educated clients on the basic purpose for taking particular medications and provided support so clients were enabled to actively participate in their programs. Findings include: 1) On 10/25/23 at 03:40 PM observed medication administration for Client (C)4. C4 came to the kitchen, Direct Care Staff (DCS)1 removed the client's plastic bin from the drawer of the file cabinet and dispensed the medications. Review of C4's Medication Self-Administration Program noted C4 is able to identify correct medication bin and to cue the client to remove their medication bin from the cabinet or from the bin choices placed on the counter top. The client was not observed to perform this task. The program also documented C4 is independent in throwing cup away into trash and able to replace blister pack or bottle in the medication bin. This was not observed. On 10/25/23 at 03:57 PM observed C1 wheel C2 to the kitchen for medication. DCS1 removed his plastic	W0371		

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W0371	Continued from page 3 bin from the cabinet and ask C2, are you [NAME], is your name [NAME]? DCS1 poured the medication into the plastic cup. C2 took his first medication and began to wheel himself away. C2 had to be prompted and asked to return to take his second medication, docusate sodium. A review of C2's program noted the client will work toward replacing the bottle (or blister pack) in medication bin. C2 noted to be partially dependent for identifying correct medication bin. C2 needs cueing to remove the medication bin from the cabinet or from the bin choices placed on the countertop. Other tasks C2 is partially dependent was to throw cup away into trash and replace blister pack or bottle in medication bin. C2 was not observed to receive prompts or hand over hand assistance to perform these tasks. On 10/25/23 at 04:00 PM observed C5 come to the kitchen for medication. DCS1 removed the bin from the cabinet, showed C5 the bin and asked is that you [NAME]. A review of C5's program noted the goal is for C5 to achieve maximum understanding of and independence in the process of self-administering medications. The objective was for C5 to become independent in identifying his medication bin. This objective was not observed, C5 was not cued by staff to identify his medication bin from the cabinet or choice placed on countertop. 2) On 10/25/23 at 03:40 PM observed medication administration of four clients. Only one client was observed to participate in popping the blister pack. The medication cup was placed in a bowl and the client was provided with hand over hand assistance and was able to pop the pill into the bowl (missed the medication cup). On the afternoon of 10/26/23 at 06:47 AM observed medication administration for three clients. Observed DCS4 assist clients with popping their medication from the blister pack. The blister pack was placed over a bowl, DCS4 provided hand over hand assistance and cueing, and clients were able to perform this task partially independent. DCS4 offered C3 a choice of fluids to take with her	W0371		

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W0371	Continued from page 4 medications. DCS4 also asked C3 why she took certain medications (i.e., seizure, behavior) and when unable to respond, DCS4 educated the client.	W0371		