PRINTED: 03/20/2017
FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	12G030	A. BUILDING: ______ B. WING ______	03/10/2017

NAME OF PROVIDER OR SUPPLIER
OPPORTUNITIES AND RESOURCES, INC (HOL

STREET ADDRESS, CITY, STATE, ZIP CODE
64-1510 KAMEHAMEHA HIGHWAY
WAHIAWA, HI 96786

(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) COMPLETE DATE
9 000	INITIAL COMMENTS A State re-licensure survey was conducted at the facility from 3/8 - 3/10/17. At the time of entrance, there were 3 clients residing in House 1-A.	9 000	RECEIVED 2017 APR 24 P 1:49 STATE OF HAWAII OH-OHCA MEDICARE	
9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM A plan of treatment shall be developed and implemented for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional, and vocational level. This Statute is not met as evidenced by: Based on observation, clinical record review and interview with staff, the facility failed to implement a plan of treatment for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional and vocational level for 2 of 3 clients (Clients #3 & #2) in the case sample. Findings include: 1. Client #3's 3/2/17 Individual Habitation Plan (IHP) found he was admitted on 9/1/95 with diagnoses including mild mental retardation, [redacted], myopia and diabetes mellitus, among others. The client's profile states he/she "has a history of engaging in a range of challenging behaviors including walking away when over stimulated/upset...is verbal and indicates some of...wants and needs, although, he often prefers to read or write alone and likes quiet environment." The IHP also noted a "continuation of behavioral interventions and data collection..." with relation to the client's Positive Behavioral Support Plan (PBSP) to reduce incidents of hoarding or running away.	9 005	On 4/4/2017, the QIDP reminded the day program staff and direct care staff to encourage client #3 to participate in the active treatment training program plans in reading and writing. The QIDP had an in-service training to all ORI staffs on the proper implementation on the active treatment training program plans including positive behavior support plans on each client to ensure that aggressive active treatment training is provided in sufficient number and frequency, and that training and interventions are implemented consistently. Regular in-service training will be conducted by the QIDP to all ORI staffs on an as needed basis for the consistent implementation on client's active treatment training program plans and positive behavior support plans. The QIDP will continue to monitor ORI staff during Tuesday's weekly caregivers meeting to ensure that clients active treatment training program plans and positive behavior support plans are provided in sufficient number and frequency and that training goals and interventions are implemented consistently.	4/4/2017

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Program Administrator — (X6) DATE: 4/20/2017

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9 005	Continued From page 1 The client's active treatment for his PBSP program noted for "Running Away: (Client) will calmly participate in daily activities and verbally communicate to staff when (he/she) needs a quiet time." Although there was documentation tracking the frequency of incidents for the client's behaviors related to running away, there was no observation that staff were intervening and meeting the program requirement for the client as there was no programming observed when the client self removed him/herself from the day program on 3/8/17 and from the home on 3/9/17. Observation done on 3/8/17 at from 1:45 PM until 2:40 PM, found Client #3 sitting in the large hall, with the lights turned off. There was no ventilation in the hall and the client was visibly perspiring as it was warm in the hall. The client also held onto a stack of paper with handwritten notations on it that were undecipherable. The client responded, "I don't know," when asked where everybody was and if he/she was reading or writing anything. The client was not provided with any programming during that time, although the client's active treatment plan notes the client should be receiving day program training. Then at 2:47 PM, the client returned to the classroom setting. He/she sat next to Staff #8 and began making continuous and repetitive loops on a piece of paper. Staff #8 was observed to praise the client and said, "You are writing your name? Very good!" However, when Staff #8 was asked if the client was writing his/her name, she said, "Oh, I can't read it" and smiled. On the morning of 3/9/17 at 6:45 AM, Client #3 was observed to exit the home and went across to the Kwong Hall. The client used the remote to turn on the large flat screen TV and proceeded to	9 005		

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9 005	Continued From page 2 sit and watch the news. Staff #4 confirmed this was one of the client's behaviors, but did not know how she was to intervene. Staff #4 said when the client became disagreeable or "if (he/she) doesn't get (his/her) way, (he/she) will run away." Staff #4 said it was difficult to redirect the client and confirmed the client did this daily. Staff #4 said the client also did not verbally communicate to staff when he/she needed quiet time, but would just take off. Staff #4 said the running away however, has been limited to the hall or to a nearby house on the premises, and not like years prior when the client used to walk out to the highway area. Staff #4 confirmed they need to better monitor the client but did not know what the client's PBSP interventions included. On 3/9/17 at 9:30 AM, Client #3 was again observed sitting in the large conference room sitting in the dark by him/herself. The client was writing repetitive curvy lines on a piece of paper. The client was not in the day program classroom where the other clients were doing their programming with instructor oversight. During an interview with Staff #5, she was asked how Client #3 was monitored to complete his/her programs when he/she ran out of the classroom with no staff preventing him/her from doing so. Staff #5 stated, "We don't bother the client" after also being informed of the SA's observations of the client on 3/8/17 with no programming being done. Staff #5 said the client, "is supposed to write some functional words like exit, entrance, push, pull and hot." Staff #5 was told none of this was observed during the past two days in either the day program and home. Staff #5 said the interventions related to the client's PBSP were to praise the client which has decreased the running off. Staff #5 agreed and stated, "it's not the type of programming for (client)" to be self-removed	9 005		

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9 005	Continued From page 3 from the day program and to sit in the adjacent, darkened hall doing nothing when he/she should be completing his/her active treatment programming in the classroom. As such, Client #3's PBSP was not being implemented in all environments and as a result, the client's active treatment programming for areas such as in reading and writing were not being met as well. 2. On the 3/8/17, Client #2 was not seen to be receiving a continuous active treatment program as outlined in the client's IPP. Client #2 was observed sitting in a cubicle by him/herself for one hour and 25 minutes with nothing to do and without interaction from staff or other clients. At this time Staff #5 interacted with Client #2 for less 5 seconds. They placed a book in front of Client #2 with the words "exit" and "entrance" written on it, and for Client #2 to copy and practice his/her writing skills. After Staff #5 left, Client #2 closed the book without completing any of the task. Thirty-five minutes later, Staff #5 returned for less than 5 seconds, leaving a large piece jigsaw puzzle in front of Client #2. Client #2 completed the puzzle in less than 30 seconds and remained sitting in the cubicle with no further interaction from staff or other clients until 30 minutes later. Client #2 did not follow or engage in any active treatment or activity during this time. On the morning of the 3/9/17 in the house where Client #2 resides, the client was observed sitting in a chair by the door for 60 minutes doing nothing, with no interaction from staff or other clients. When Staff #4 was questioned if Client #2 did any active treatment programing in the morning while waiting to go to the day program, Staff #4 then placed four large piece jigsaw	9 005	On 4/4/2017, the QIDP reminded the day program staff and direct care staff on the proper implementation for client #2's overall active treatment training program plans to function at his greatest physical, intellectual, social, emotional, and vocational level by constant interaction and encouragement for him to progress. The QIDP had an in-service training to all ORI staffs on the proper implementation on the active treatment training program plans including positive behavior support plans on each client to ensure that aggressive active treatment training is provided in sufficient number and frequency, and that training and interventions are implemented consistently. Regular in-service training will be conducted by the QIDP to all ORI staffs on an as needed basis for the consistent implementation on client's active treatment training program plans and positive behavior support plans. The QIDP will continue to monitor ORI staff during Tuesday's weekly caregivers meeting to ensure that clients active treatment training program plans and positive behavior support plans are provided in sufficient number and frequency and that training goals and interventions are implemented consistently.	4/4/2017

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9 005	Continued From page 4 puzzles in front of Client #2. These puzzles were well worn from age and use. Client #2 was able to finish each puzzle in less than 20 seconds. Interview on 3/9/17 with Staff #5 was conducted and Staff #5 validated that Client #2 is not given the interaction and encouragement to progress with his/her active treatment and that no new programs have been introduced to encourage progress for Client #2.	9 005		
9 134	11-99-13(2)(E) GOVERNING BODY AND MANAGEMENT Written policy shall prohibit mistreatment, neglect, or abuse of residents. Alleged violations shall be reported immediately, and there shall be evidence that: (i) All alleged violations are thoroughly investigated and documented. This Statute is not met as evidenced by: Based on observations, interviews and review of the facility's policy and procedure on abuse and neglect, the facility failed to ensure that all alleged violations shall be reported immediately, and there shall be evidence that all alleged violations are thoroughly investigated and documented for 1 of 3 clients (Client #1) in the case sample. Finding includes: An abuse investigation was initiated during the survey by the Hawaii State Survey Agency (SA) based on a DHS report received by the SA on 2/16/17. The report outlined allegations of psychological abuse and caregiver neglect by Staff #1 toward Client #1, while the client resided	9 134		

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9 134	Continued From page 5 in his/her home with Staff #1 present. Staff #1 was the client's home manager/caregiver and lived with the client and two other clients in the 1-A home. During the survey, it was found that on 2/8/17, the facility was notified by a DHS case worker that Client #1 reported being afraid of Staff #1. At that time, Client #1 stated the staff was mean, pushed the client and slapped his/her head. Staff #1 also allegedly threw a box of medications at the client. On 3/8/17, the SA reviewed the facility's policy and procedure on abuse and neglect (last revised 9/04). It stated: "Procedures: A. ...staff shall: If, in the performance of their professional or official duties, know or have reason to believe that a client has been abused and/or neglected, and/or is threatened with imminent abuse shall: 1. immediately take whatever actions are appropriate and necessary to ensure that no further harm comes to the client...3. make a written report to the Case Manager/QMRP or the ICF-MR Director per ORI's policy and procedures for incident reporting. B. ORI's Small ICF-MR Case Manager/QMRP shall: 1. assure all new and current staff are trained in ORI's abuse and neglect policies and procedures for detecting and following up on allegations of abuse and neglect. 2. immediately take appropriate steps necessary to assure that no further harm comes to the client, including but not limited to prohibition of any further contact between the alleged perpetrator and any and all clients of the facility until such time as a thorough investigation can be completed...4. immediately conduct a review of the incident by meeting face to face with the client to assess the situation and develop strategies to ensure the safety of the client and others...6. notify the guardian or family representative of the	9 134	On 4/4/2017, the PA reviewed the ORI's policy and procedures on abuse and neglect and the regulatory requirements for ICF/IID for the protection of client #1 from abuse and neglect. The PA had an in-service training to all ORI staff on the policies and procedures for reported abuse and/or neglect as part of each client protections to identify abuse and neglect and prevent recurrence of such events. Regular in-service training will be conducted to all new and current staff in ORI's policies and procedures on abuse and neglect for detecting and following up on allegations of clients abuse and neglect on an as needed basis and if known or have reason to believe that a client has been abused and/or neglected, and/or is threatened with imminent abuse shall immediately take whatever actions are appropriate and necessary to ensure that no further harm comes to the client. The PA will continue to monitor ORI staff during Tuesday's weekly caregivers meeting to ensure that all alleged violations on ORI's policies and procedures on clients abuse and neglect shall be reported immediately in writing to the office, and there shall be evidence that all allegations are thoroughly investigated and documented.	4/4/2017

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9 134	Continued From page 6 client involved, immediately in cases of severe injury or death, and within one business day in other cases. 7. assure timely, accurate, and complete documentation regarding all alleged incidents per ORI's policy and procedures for Incident Reporting. 8. keep the administrator informed of developments in the investigation and submit a full written report to the administrator within 5 days of the incident." During the interview with the PA on 3/8/17 at 9:20 AM, he verified he failed to conduct a thorough investigation, which at the minimum, would have included the following: a) the collection of all interviews, statements, physical evidence and any pertinent maps, pictures or diagrams; b) a review and analyses of all investigative information; c) a summary of conclusions; and d) actions taken to safeguard all the clients during the investigation and after the completion of the investigation and report. The PA's interview validated the lack of this being done and he confirmed that he thought the Adult Protective Services (APS) investigation was part of their investigation. The PA said APS was on-site to do an investigation on 2/9/17, the day after the DHS case manager came. He said APS's investigation was related to allegations of Staff #1's mistreatment of Client #1 (outlined in the DHS report by Client #1's case manager). It had been the case manager who arrived at the facility on 2/8/17 and requested the initial meeting based on Client #1's concern regarding his/her home manager/caregiver (Staff #1). The PA said as a result of the initial visit from the case manager on 2/8/17, he and another staff met with both Staff #1 and Client #1 individually at 3:00 PM at the client's home that same day. The PA said upon asking Client #1 about his concern	9 134		

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9 134	Continued From page 7	9 134		

regarding Staff #1, "the client said it was true--the throwing of the empty box and later, we spoke with (Staff #1) and she admitted she threw it at (Client #1), but did not hit the client." The PA said the next day however, APS showed up at the facility and when they interviewed Staff #1, "she admitted to APS it was due to her frustration, so that is my, our presumption that her intention was to hit the client."

The PA further stated, "I didn't make any written report because the following day, I should have. I admit to this." He said he went to personnel to verbally inform them of what Staff #1 had stated. However, he said he failed to remove Staff #1 from the home on the evening of 2/8/17 and it was not until the next day after APS left that "she was suspended and I told her to go home already." The PA admitted he thought the APS investigation was the complete investigation and said, "I did not make a report, just a verbal report." When the PA was further queried why they terminated Staff #1 if there was no documented and/or completed investigation done, he stated, "The President made a decision because it's not good for the caregiver to do this." The PA verified this was abuse on the part of Staff #1's actions toward Client #1.

In a written letter dated 2/9/17 to ORI's President, the PA stated it was based on APS's investigation and questions to Client #1, and none of their own investigation. He verified based on APS's investigation, it was verified that not only did Staff #1 throw an empty medication box at Client #1, but Staff #1 also admitted to aiming her hand at the client but did not physically hurt the client. In addition, from the APS investigation, Client #1 alleged he/she was scared of Staff #1, that this caregiver also fought with him/her, and "slaps"

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9 134	Continued From page 8 the client's head and back. The PA said they failed to follow their policy on abuse and neglect and the regulatory requirements for ICF/IID for the protection of clients from abuse and neglect. The PA stated they did an in-service for the caregivers regarding this incident thereafter. He said he did not know why they did not remove Staff #1 immediately after talking with Client #1 on the afternoon of 2/8/17. He said, "We never thought that--we do not weigh it as ah, we just thought the client was telling a lie because the caregiver (Staff #1) said she did not hurt him, and we only came to analyze the caregiver the following day when APS came." He verified he did not have any documented witness statements from either Client #1 or Staff #1. On 3/9/17, Staff #3 gave the SA an incident timeline of events which she said she typed up on 3/8/17 outlining the eventual termination of Staff #1. On 3/8/17 at 12:10 PM, the SA interviewed Client #1 in the day program. Client #1 is able to understand, is receptive and answered the client interview questions appropriately. During the interview, he/she said most of the staff are polite to him/her, but that Staff #1 was not and "always fight with me, throw medicine at me. She not here now because she quit already." Client #1 said he/she reported Staff #1 because she was mean. Client #1 teared up during the interview discussing Staff #1 but said he/she currently feels safe living in the home. The facility thus failed to ensure they conducted a thorough investigation and also failed to develop a tracking system as part of client protections to identify abuse and neglect and prevent recurrence of such events.	9 134		

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9 171	11-99-19(b) MAINTENANCE There shall be records that document compliance with environmental safety codes of the state and county authorities having primary jurisdiction over the facility. Inspection of all devices essential to health and safety of residents and personnel shall be carried out daily or at sufficiently frequent intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect, furnish and maintain in good repair, some of the furniture, devices and electronic equipment for the clients' use in their home for 3 of 3 clients (Clients #1, 2, and 3) in the case sample. Finding includes: During the observation of the clients' home on 3/8/17 at 3:30 PM, it was found that the call system for all three clients residing in the home did not function. Staff #6 tested each call light in the clients' rooms and verified they were not working. Staff #6 stated the call lights were important "so that if they (clients) need any help, we can go to them." Staff #6 also uncovered the bedsheet covering one of the loveseat sofas in the living area and pointed out that there were "tears" in the beige colored sofa seats. Staff #6 said that was the reason for covering it. In addition, five of the six dining room chairs had chair legs which were splintering at the ends but were taped with scotch tape. Staff #6 stated the chairs in this condition, "should be repaired." She	9 171	On 4/4/2017, the PA immediately issued a work order to maintenance personnel to replace the call system for all three clients residing in the home, replacing the love seats sofa and repairing the dining chairs. Replacement and repairs were completed. The living room TV in House 1A was working but was not connected to cable or a DVR at the time of the survey. An in-service training was provided to all direct care staff's in the home by the QIDP on 4/4/2017, to inspect, furnish and maintain in good repair some of the furniture, devices and electronic equipment for each client use in their respective rooms. Regular in-service training will be conducted by the QIDP periodically and any need for repair or replacement will be reported to the PA or QIDP who will initiate repair or replacement. The QIDP will continue to monitor ORI staff during Tuesday's weekly caregivers meeting to ensure that the staff's inspect some of the furniture, devices electronic devices equipment in their homes in compliance with environmental safety codes of the state and county authorities having jurisdiction over the facility.	4/4/2017

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9 171	Continued From page 10 said the maintenance is responsible for the upkeep. On the morning of 3/9/17, after it was observed how Client #3 left the house to watch the large screen TV at the Kwong Hall across the home, it was found the client's TV in the home living area was not working. This was confirmed by Staff #4 at 6:45 AM. Staff #4 did not know how long the TV had not been working as she rotated to cover the home from 2/15/17 after Staff #1 was terminated.	9 171		
9 185	11-99-22(a) PHARMACEUTICAL SERVICES The facility shall employ a licensed pharmacist, or shall have formal arrangements with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal, record-keeping of drugs and biologicals, and provision for emergency service. This Statute is not met as evidenced by: Based on record review the facility failed to ensure the pharmacist and QIDP reviewed and the client did not receive PRN (as needed) medications for behavior control for 1 of 3 clients (Client #2) in the case sample. Finding includes: Record review for Client #2 conducted on 3/9/17 revealed the client had a PRN order for Lorazepam 2 milligrams (mgs) every 4 hours orally for severe agitation and anxiety. It was not reflected in his/her IPP as an intervention for his/her behaviors. The client had received this	9 185	On 4/18/2017, the QIDP reminded all ORI staff's that PRN (as needed) medications used for client's behavior control must be used only as an integral part of their individual program plan that is specifically towards the reduction of and eventual elimination of the behaviors for which drugs are employed and each for dose given, a physician must be contacted for the onetime order for the administration of the medication.	4//18/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AMENDED POC	12G030	A. BUILDING: ____ B. WING ____	03/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOL	64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786

(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) COMPLETE DATE
9 185	Continued From page 11 medication last on March 6, 2017. The PA stated he was not aware that PRN medications for behavior control were not allowed.	9 185		