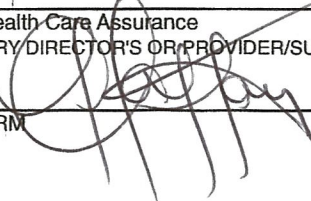


Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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	<b>INITIAL COMMENTS</b>  A licensing survey was conducted by the Hawaii State Survey Agency from March 8 to March 10, 2017.	9 000		
9 081	<p><b>11-99-9(a) DIETETIC SERVICES</b></p> <p>The food and nutrition needs of residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex, activity, and disability. This Statute is not met as evidenced by: Based on observation, record review and staff interview the facility did not provide a modified diet to a diabetic client.</p> <p>Finding includes:</p> <p>On March 8, 2017 at 4 PM observed C #2 at the table drinking a Capri Sun Juice bag and eating a chocolate pudding from a disposable cup. Record review found C #2 had a diet order for "low concentrated sweets, controlled carbohydrate". The Staff #4 was interviewed and asked if C#2 was offered low sugar snacks. Staff #4 stated, "no, I don't have that". At 4:15 PM Staff #4 did a fingerstick blood sugar test on C#2 and the BS reading was 368. Observed in the hallway in the home a poster titled, "Snack for diabetics" that recommended sugar free foods and avoiding snack puddings.</p> <p>Failure to follow the recommended diabetic dietary intake puts the resident at risk for high blood sugars and health complications.</p>	9 081	<p style="text-align: center;">STATE OF HAWAII DHHS - OHCA MEDICARE RECEIVED 2017 APR 24 P 1:50</p> <p>On 3/14/2017, the QIDP had an in-service training with the direct care staff on client #2's meal nourishment consistent with the diet order for "low concentrated sweets, controlled carbohydrate prescribed by the Nutritionist. The QIDP reminded the direct care staff to follow the recommendation of the Nutritionist that clients will have a modified diet to all diabetic clients. Regular in-service training will be conducted to all caregivers and especially to the direct care staff whenever there is a need and at least annually. The QIDP will continue to monitor all caregivers during Tuesday's weekly caregivers meeting to ensure that proper understanding on the training and that fruits and vegetables are given for snacks to clients with Diabetes Mellitus and avoiding snack puddings.</p>	3/14/17

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Administrator	(X6) DATE 4/20/17
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FORM

6899

663911

If continuation sheet 1 of 19

1.24.17 - copy to 15:16

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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9 000 INITIAL COMMENTS  
  
A licensing survey was conducted by the Hawaii State Survey Agency from March 8 to March 10, 2017.

9 000

9 081 11-99-9(a) DIETETIC SERVICES  
  
The food and nutrition needs of residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council adjusted for age, sex, activity, and disability.  
This Statute is not met as evidenced by:  
Based on observation, record review and staff interview the facility did not provide a modified diet to a diabetic client.

9 081

Finding includes:

On March 8, 2017 at 4 PM observed C #2 at the table drinking a Capri Sun Juice bag and eating a chocolate pudding from a disposable cup. Record review found C #2 had a diet order for "low concentrated sweets, controlled carbohydrate". The Staff #4 was interviewed and asked if C#2 was offered low sugar snacks. Staff #4 stated, "no, I don't have that". At 4:15 PM Staff #4 did a fingerstick blood sugar test on C#2 and the BS reading was 368. Observed in the hallway in the home a poster titled, "Snack for diabetics" that recommended sugar free foods and avoiding snack puddings.

Failure to follow the recommended diabetic dietary intake puts the resident at risk for high blood sugars and health complications.

On 3/14/2017, the QIDP had an in-service training with the direct care staff on client #2's meal nourishment consistent with the diet order for "low concentrated sweets, controlled carbohydrate prescribed by the Nutritionist. The QIDP reminded the direct care staff to follow the recommendation of the Nutritionist that clients will have a modified diet to all diabetic clients. Regular in-service training will be conducted to all caregivers and especially to the direct care staff whenever there is a need and at least annually. The QIDP will continue to monitor all caregivers during Tuesday's weekly caregivers meeting to ensure that proper understanding on the training and that fruits and vegetables are given for snacks to clients with Diabetes Mellitus and avoiding snack puddings.

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 STATE OF HAWAII  
 DOH-OHCA MEDICARE

3/14/17

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>President &amp; CEO</i>	(X6) DATE <i>3/24/2017</i>
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Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

12G031

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_\_\_\_\_

B. WING: \_\_\_\_\_

(X3) DATE SURVEY COMPLETED

03/10/2017

AMENDED POC

NAME OF PROVIDER OR SUPPLIER

OPPORTUNITIES AND RESOURCES, INC (HOL

STREET ADDRESS, CITY, STATE, ZIP CODE

64-1510 KAMEHAMEHA HIGHWAY  
WAHIAWA, HI 96786

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9 091	Continued From page 1	9 091		
9 091	<p>11-99-9(d)(2)(A) DIETETIC SERVICES</p> <p>All food shall be procured, stored, prepared, distributed, and served under sanitary conditions. This Statute is not met as evidenced by: Based on observation and staff interview, the facility did not promote, support, reinforce and encourage clientel to eat in an appropriate and normalized manner.</p> <p>Findings include: Cross reference to W 455. On 03/08/2017 at 12:20 p.m. observed a random client during dining. Client was observed waiting near the trash bin. When another resident cleaned their plate off into the trash and left, the random client quickly grabbed a piece of chicken out of the trash. Random client quickly started to eat the chicken and went off to the side of the dining hall. Another client scraped their plate into the trash. Random client was again waiting near the trash area and swiped the dirty plate stacked on dirty dishes and grabbed remaining rice on plate and placed it into his mouth and ate what he had grabbed off the plate. One of the staff redirected random client. Within a minute, random client was waiting again by the trash area, he watched as another client cleaned their plate into the trash bin. As soon as he could, he swiftly went straight to the trash and grabbed a piece of chicken and started to eat it.</p> <p>Interview on 03/08/2017 at 12:30 with Staff #3 (S3). I discussed this situation with S3 and she stated that "we try to keep him from doing that". This surveyor asked if the lid for the trash bin may deter him from reaching into the trash. S3 got up and put the trash cover on the bin.</p>	9 091	<p>9 091 11-99-9(d)(2)(A) DIETETIC SERVICES</p> <p>On 3/14/2017, the QIDP reminded the DP Staff regarding the behavior of a random client who quickly grabbed a piece of chicken out of the trash bin and started to eat it during meal times. The QIDP had an in-service training to all ORI staffs to see to it that during meal times one staff should be alert at all times and maintain a lid cover for the trash bin to deter clients from reaching into the trash bin. Regular in-service training will be provided to all ORI staffs during Tuesday weekly caregivers meetings to ensure that they encourage clients to eat in an appropriate and normalized manner not taking food in the trash bin. The QIDP will continue to monitor all DP staff and ORI staffs from 12:00PM to 12:30PM- Monday to Friday during meal times to ensure that clients are encouraged to eat in an appropriate and normalized manner and to maintain a lid cover for the trash bin to deter clients from reaching into the trash bin</p>	3/14/17

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9 091	Continued From page 2  On 03/10/2017, this scenario was discussed with Staff #2 (S2) and S2 stated he heard about this situation and would be addressing this.	9 091		
9 150	<p>11-99-15(a) INFECTION CONTROL</p> <p>Provision shall be made for isolating residents with infectious diseases, until appropriate transfer can be made. There shall be a written policy which outlines proper isolation and infection control techniques and practices.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to practice an active program for the prevention and control of infection and communicable disease.</p> <p>Findings include: 1) On 03/08/2017 at 12:20 p.m. observed a random client during dining. Client was observed waiting near the trash bin. When another resident cleaned their plate off into the trash and left, the random client quickly grabbed a piece of chicken out of the trash. Random client quickly started to eat the chicken and went off to the side of the dining hall. Another client scraped their plate into the trash. Random client was again waiting near the trash area and swiped the dirty plate stacked on dirty dishes and grabbed remaining rice on plate and placed it into his mouth and ate what he had grabbed off the plate. One of the staff redirected random client. Within a minute, random client was waiting again by the trash area, he watched as another client cleaned their plate into the trash bin. As soon as he could, he swiftly went straight to the trash and</p>	9 150	<p>9-150 11-99-15(a) INFECTION CONTROL</p> <p>1). On 3/14/2017, the Nurse had an in-service training with ORI staffs for the prevention and control of infection and communicable diseases by not allowing clients to eat leftover scraped foods in the trash bin. Day Program staffs were reminded to always keep the trash bin closed so that clients will not pick left over foods in the trash bin. Regular in-service training will be provided by the Nurse to ORI staffs to ensure that clients will not eat left over scraped foods thrown in at the trash bin to prevent and control infection and communicable diseases. The Nurse will continue to monitor all ORI staffs during Tuesday's weekly caregivers meeting to ensure that trash bin is closed at all times to deter clients from taking left over foods in the trash bin for the prevention and control of infection and communicable disease.</p>	3/14/17

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9 150	<p>Continued From page 3</p> <p>grabbed a piece of chicken and started to eat it.</p> <p>Interview on 03/08/2017 at 12:30 with Staff #3 (S3). I discussed this situation with S3 and she stated that "we try to keep him from doing that". This surveyor asked if the lid for the trash bin may deter him from reaching into the trash. S3 got up and put the trash cover on the bin.</p> <p>On 03/10/2017, this scenario was discussed with Staff #2 (S2) and S2 stated he heard about this situation and would be addressing this.</p> <p>2) On 3/8/2017 at 19:50 AM observed in the activity room a volunteer staff person giving a massage to 12 random clients and staff persons. The volunteer had each person sit in a chair and rubbed their back, shoulders without hand sanitizing between massages. Later that day Staff #1 was asked if hand sanitizing should have occurred between touching each resident and staff. Staff #1 stated there should have been hand sanitizing to control the spread of infections.</p> <p>3) In the morning of 3/8/2017 observed a Client #2 in the program activity room. C #2's eyes were very red and weeping yellow drainage from both eyes. A staff person was called and asked what was going on with C #2's eyes. The staff person said would take C #2 to see the nurse. Later that afternoon 4:15 PM Staff #1 came to the home to deliver medications. Staff #1 realized there was no eye drops for C#2's eyes. Interviewed Staff #2 about C #2's eyes and learned that C #2 spend the day in Kwon Hall due to having symptoms of "pink eye". C #2 was prescribed eye drop antibiotics. Neomycin and Olympian 4 guts, 4 times a day, however the medication was not started yet. At 4:55 PM C #2 was taken to the main dining room for dinner. C</p>	9 150	<p>2). On 3/14/2017, the Nurse counseled the volunteer staff person giving massages to clients to always sanitize her hands in between touching each resident and staff.</p> <p>3). On 3/14/2017, the Nurse had an in-service training with the direct care staff on client #2's both eyes reddish in color and weeping yellow drainage to be separated from other clients for the prevention and control of infection and communicable diseases. All ORI staffs were reminded by the Nurse to segregate clients who have reddish eyes and weeping yellow drainage from interacting with other residents and staffs. Regular in-service training will be provided by the Nurse to ORI staffs to ensure that clients who have teary eyes and weeping yellow drainage will</p>	<p>3/14/17</p> <p>3/14/17</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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9 150	<p>Continued From page 4</p> <p>#2 was observed wiping her eyes and touching the serving spoon at the buffet line. Staff #4 was told about this observation and removed C#2 from the dining room with her plate of food. Staff was told to remove the serving spoon C#2 had touched. The facility policy on communicable disease states, "clients with respiratory tract symptoms will be excluded from duties relating to food handling and from other direct contact with other staff and residents".</p> <p>4) In the morning of 3/9/2017 observed Staff #3 instructing C#1, #2, #3, and #4 to go to the sink and get a cup for medications at separate time. Observed in the kitchen a sink drain with washed cups. Staff #5 was asked if the dishes in the sink had been rinsed with Clorox and replied that was going to be done later. The facility dishwashing policy states, "Sanitize in a solution of 1 tablespoon chlorine bleach per gallon of tap water for 1 minute.</p> <p>Failing to follow infection and communicable disease guidelines and recommendations is an infection control concern.</p>	9 150	<p>be excluded from duties relating to food handling and from other direct contact with peers and staffs to prevent and control infection and communicable diseases. The Nurse will continue to monitor all ORI staffs during Tuesday's weekly caregivers meeting to ensure that clients with respiratory tract symptoms (teary eyed with yellowish drainage) will be excluded from duties relating to food handling and from interacting with peers and staffs for the prevention and control of infection and communicable diseases.</p> <p>4). The direct care staff was reminded by the Nurse to follow the facility dishwashing policy which states, "Sanitize in a solution of 1 tablespoon chlorine bleach per gallon of tap water for 1 minute", all dishes used in the sink and let it dry before using it.</p>	3/14/17
9 186	<p>11-99-22(b) PHARMACEUTICAL SERVICES</p> <p>Medications administered to a resident shall be ordered either in writing or verbally by a physician so authorized by facility policy.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility has an as needed prescription order for medication to manage behavior. Findings include:</p> <p>1) Record review: Client #1 has an order written</p>	9 186		

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9 186	<p>Continued From page 5</p> <p>Diazepam 5 mg (Valium 5 mg), take one tablet by mouth every four hours whenever needed. Not to exceed two tablets in 24 hours for severe agitation.</p> <p>Interview on March 9, 2017 with Staff #1 (S1) at 1:48 PM. S1 stated that she was not aware of the regulation that states "Drugs for behavior management must not be ordered on a whenever needed basis for a client. S1 stated that she would get familiar with the regulations pertaining to whenever needed medications.</p> <p>2) On March 9, 2017 found in C#4's medication order included "Lorazepam 1 mg and Ativan 1 mg BID PRN". Interviewed Staff #1 that same day regarding as needed medications for behavior. Staff #1 was not aware that drugs ordered to manage behavior must not be ordered PRN.</p> <p>Drugs used for behavior must be integrated in the clients IPP and each for dose given as needed a physician must be contacted for the one time order.</p>	9 186	<p>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.</p>	4/18/17
9 191	<p>11-99-22(e) PHARMACEUTICAL SERVICES</p> <p>Only appropriately trained staff shall be allowed to administer drugs and shall be responsible for proper recording of the medication, including the route of administration. Such persons shall have satisfactorily completed a course of training in the administration of drugs, which course has been approved by the Department. Medication errors and drug reactions shall be recorded in the resident's</p>	9 191		

Hawaii Dept. of Health, Office of Health Care Assurance

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9 191	<p>Continued From page 6</p> <p>chart and reported immediately to the physician who ordered the drug and an incident report shall be prepared. All incident reports shall be kept available for inspection by the Director.</p> <p>This Statute is not met as evidenced by: Based on observation, staff interview and record review, a medication error occurred during observation of medication passage which resulted in a discrepancy between what is ordered and how it was administered.</p> <p>Findings include: Observation: On 03/08/2017 Client#1 (C1) was scheduled for 12:00 medications. Medications included Renvela 800 mg, take 2 tabs by mouth three times a day with meals; CVS Ferrous Sulfate, take 1 tab 3x a day with food for Anemia. C1 refusing her meds and refusing to eat. C1 took her meds at 0200 p.m. on 03/08/2017.</p> <p>Record review on 03/09/2017 reveals that Renvela and Ferrous sulfate scheduled for 12:00 and charted given at 12:00; however, observation of medications on 03/08/2017 is that the resident took her medications at 0200 p.m. Documentation in record of medication administered documented at 12:00.</p> <p>Interview with S1 on 03/09/2017 at 1:50 p.m. S1 confirmed that administration of meds two hours late was a medication error. S1 stated that she would be doing some training regarding medication administration and medication documentation.</p>	9 191	<p>On 03/14/2017, The Nurse reminded the Day Program staff and all ORI staffs the importance on client #1's timely medication administration and proper signing of client's medication in the medication administration record if actually administered to the client. The Nurse had an in-service training to all ORI staffs in proper procedure in the preparation of medications, proper timely medication administration and proper recording of all medications including the signing specifying the actual time each client's medication is actually administered to the client. Regular in-service training will continue to be provided by the Nurse to all ORI staffs during Tuesdays weekly caregivers meetings and at least quarterly on the proper implementation on the procedures for timely administration of client's medications and proper signing of client's medication in the medication administration specifying the time the medication is actually administered to the client. The Nurse will continue to monitor Day Program Staff and all ORI staffs from 12:00P-1:00PM to ensure timely administration of client's medication including signing of the client's medication administration if actually administered and properly implemented.</p>	
9 275	11-99-29(a)(6) RESIDENT'S RIGHTS	9 275		



Hawaii Dept. of Health, Office of Health Care Assurance

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9 275	<p>Continued From page 7</p> <p>Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall:</p> <p>Be encouraged and assisted throughout their period of stay to exercise their rights as a resident, and to this extent voice grievances and recommend changes in policies and services to the facility's staff or outside representative of their choice, free from restraint, interference, coercion, discrimination or reprisal.</p> <p>This Statute is not met as evidenced by: Based on observation, policy review and staff interviews the facility did not ensure that clients are not subjected to physical and verbal abuse.</p> <p>Cross reference to W122</p> <p>Findings include:</p> <p>On the morning of 3/9/2017 at 6:30 AM observed in the home Client #1 (C#1), Client #2 (C#2) and Client #3 (C#3) seated at the dining table having breakfast. Client #4 (C#4) was seated on the living room sofa. C#1 was yelling intermittently in a deep voice sounding like a seal bark. C#3 was also crying and yelling at the table.</p> <p>At 6:55 AM observed C#3 approach C #1 in the</p>	9 275	<p>9 275 11-99-29(A)(16) RESIDENT'S RIGHTS</p> <p>On 3/20/2017, the Psychologist Consultant assessed client #1, client #2 and client #3 behavioral outbursts, like crying, yelling, screaming, hitting each other and hitting staff on the day the DOH/OHCA monitors came last 3/9/2017 in the morning and recommended that a crisis plan will be made to ensure that aggressive active treatment training is provided in sufficient number and frequency. The QIDP had an in-service training to all direct care staff and ORI staffs regarding clients unaccepted behaviors and emphasized client's implementation of active treatment training program plans and Positive Behavior Support Plans on how to redirect each client using a calm firm approach, separating them from each other and asking help from other staffs in the nearest homes so that interventions are implemented consistently. Regular in-service training will be conducted to direct care staff and caregivers on the proper handling of clients who are unruly whenever there is a need and at least annually. The QIDP will continue to monitor all ORI staffs during Tuesday's weekly caregivers meeting to ensure that aggressive 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.</p>	3/20/17
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Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_\_\_\_\_

B. WING: \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

03/10/2017

AMENDED POC

12G031

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
9 275	<p>Continued From page 8</p> <p>kitchen and hit C#1 on the back, a loud thump could be heard. C#1 went to sit back at the dining table, crying loudly with arms and legs kicking and waving. C#3 and C#1 remained in the same room. Both clients were crying. Observed during this time the Staff #4 seated at a small desk reading and pouring the medications for another client.</p> <p>C#2 stood put her food dish away, returned to the living room, pointed her finger at Staff #4 and yelled "Bad Lady! You're the Bad Lady! She's Bad!" Observed C#2 walking towards C#4 and hit her. C#4 retreated into her room and came out soon after to sit on the living room sofa next to C #2. Observed Staff #4 was pouring medications reading the medication orders out loud.. Observe C#2 point to Staff #4 and yelled, "you're not my caregiver, you're not my caregiver". Staff #4 stood C #2 hit Staff #4. Staff #4 instructed C#2 to sit down on the living room sofa.</p> <p>At 7:20 Staff #4 spoke to C #1 telling her to put back her medication box. Staff #4 then walked to the sofa where C#2 sat and administered antibiotic eye drops into C #2 eyes. Observed C #2 hit Staff #4 again. There was still no attempts made to call for outside help. Observed C #1 hit the Staff #5 and Staff #5 scream and take a jump back to avoid the hit.</p> <p>At 7:30 AM observed C #4 coming out of her room and C #1 chase C #4 who retreated back into her room. Later C #4 came back out of her room. Observed C #4 rubbing her face, pulling on her sweater. Observed C #1 standing still yelling in seal bark tones, shaking her arms. Observed Staff #4 seated at the medication desk reading medication for C #1.</p>	9 275		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

AMENDED POC

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

12G031

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_\_\_\_\_

B. WING: \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

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
9 275	<p>Continued From page 9</p> <p>At 7:50 AM observed C #1 walk into the hallway nearest to the living room. Observed C #1 hit Staff #5. In response Staff #5 yelled and moved backward to avoid the hits, stating, "she doesn't like me". There was no attempt to calm the clients or call for assistance from outside of the home. Staff #5 went into the room of C#3 who had gone into her room on her own and Staff #5 could be heard saying, "Please, please need to take a shower."</p> <p>At 8:00 AM Staff #4 went into C #3's room and could be heard pleading with C #3 to take a shower for program. C#3 could be heard crying. C #2 fell asleep on the sofa. C #4 came out of her room and asked if she could open the front door. Staff #5 gave permission.</p> <p>At 8:10 AM Staff #5 announced she was going to take C#4 to program and then go home, because her shift had ended. Staff #5 left the home with C #4 leaving Staff #4 with C#1, C #2, and C #3 in the home. By this time all clients had separated themselves on their own. C#1 and C#3 were in their rooms and C #2 was dozing on the sofa.</p> <p>Staff #5 stated this is the first time this has happened in the 2 years she has been working at the home. Staff #5 also stated C#2 is being isolated from program because of an eye infection and would be going to the Kwan Fong room located outside of the program room due to the infection.</p> <p>At 1:00 PM on the same day interviewed Staff #2. Staff #2 was asked about the training provided to manage clients who have behavior problems. Staff #2 stated: 3 things must be done. 1) Talk to the client; 2) Separate them with the first hit in a</p>	9 275		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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
9 275	<p>Continued From page 10</p> <p>proper way, keep them busy. 3) Call for a reliever outside help. Staff #2 stated there was going to be an investigation on why the situation was not handled. Staff #2 stated that was a difficult home and that was why there is a reliever assigned to the home.</p> <p>At 1:48 PM on the same day interviewed Staff #1 regarding the behaviors observed in the home that morning. Staff #1 stated she was informed about the hitting. That Staff #4 said she was nervous and did not know what to do, if one hits they are told to go in the room but this morning all the clients except C #4 were hitting. Staff #1 stated there was going to be an incident report to write up.</p> <p>At 2:08 PM Staff #2 was informed that the survey was going to take out the Client Protection Condition, become a full survey and an Immediate Jeopardy was being called. The clients were not being protected from each other, staff was not able to control the client behaviors, staff did not take measures to control the situation. Staff stated they were afraid. The facility was aware that this was a difficult home and had added a reliever staff in the morning however that reliever left one staff alone with the 3 clients who had been hitting and yelling when her shift ended. These factors warranted an Immediate jeopardy (IJ) situation.</p> <p>The facility abated the IJ that afternoon at 4:07 PM by submitting a Plan of Correction which included additional reliever in the afternoon from 3:30 PM to 7 PM. Additional reliever from 11:00 PM to 6:30 AM and 1 reliever from 6:00 AM to 8:00 AM to make 2 relievers in each shift plus the Home Manager. Training was to be provided that afternoon regarding the procedures in handling</p>	9 275		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED PCC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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
9 275	Continued From page 11  clients who are unruly hitting each other by redirecting/separating them from each other and calling other staff in the nearest homes. In service training was to be conducted by the Program Director weekly to all ORI Staff. And regular in-service training continued and as needed to ensure staff know the procedures in handling unruly clients in their respective houses.  The facility Policy on Client Rights was reviewed and states: each client shall, "1. Have the right to be free from ill treatment, physical punishment, exploitation, neglect or abuse". And 5. "Not be humiliated, harassed, or threatened."	9 275		
9 277	11-99-29(a)(8) RESIDENT'S RIGHTS  Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall:  Not be humiliated, harassed, injured, or threatened and shall be free from chemical and physical restraints. This does not exclude use of medication for treatment as ordered by a physician. Physical restraints may be used in an emergency, when necessary, to protect the resident from injury to himself or herself or others. In such an event, the resident's physician shall be	9 277		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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
9 277	<p>Continued From page 12</p> <p>notified as soon as possible and further orders obtained for care of the resident.</p> <p>This Statute is not met as evidenced by: Based on observation, policy review, and interviews the facility did not meet the Condition of Participation for Client Protections. An Immediate Jeopardy was identified in the clients' home on the morning of 3/9/2017.</p> <p>Findings include:</p> <p>On the morning of 3/9/2017 at 6:30 AM observed in the home Client #1 (C#1) , Client #2 (C#2) and Client #3 (C#3) seated at the dining table having breakfast. Client #4 (C#4) was seated on the living room sofa. C#1 was yelling intermittently in a deep voice sounding like a seal bark. C#3 was also crying and yelling at the table.</p> <p>At 6:55 AM observed C#3 approach C #1 in the kitchen and hit C#1 on the back, a loud thump could be heard. C#1 went to sit back at the dining table, crying loudly with arms and legs kicking and waving. C#3 and C#1 remained in the same room. Both clients were crying. Observed during this time the Staff #4 seated at a small desk reading and pouring the medications for another client.</p> <p>C#2 stood put her food dish away, returned to the living room, pointed her finger at Staff #4 and yelled "Bad Lady! You're the Bad Lady! She's Bad!" Observed C#2 walking towards C#4 and hit her. C#4 retreated into her room and came out soon after to sit on the living room sofa next to C #2. Observed Staff #4 was pouring medications reading the medication orders out loud.. Observe C#2 point to Staff #4 and yelled, "you're not my caregiver, you're not my</p>	9 277	<p>On 3/20/2017, the Psychologist Consultant assessed client #1, client #2 and client #3 behavioral outbursts, like crying, yelling, screaming, hitting each other and hitting staff on the day the DOH/OHCA monitors came last 3/9/2017 in the morning and recommended that a crisis plan will be made to ensure that aggressive active treatment training is provided in sufficient number and frequency. The QIDP had an in-service training to all direct care staff and ORI staffs regarding clients unaccepted behaviors and emphasized client's implementation of active treatment training program plans and Positive Behavior Support Plans on how to redirect each client using a calm firm approach, separating them from each other and asking help from other staffs in the nearest homes so that interventions are implemented consistently. Regular in-service training will be conducted to direct care staff and caregivers on the proper handling of clients who are unruly whenever there is a need and at least annually. The QIDP will continue to monitor all ORI staffs during Tuesday's weekly caregivers meeting to ensure that aggressive 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.</p>	3/20/17

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED PCC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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
9 277	<p>Continued From page 13</p> <p>caregiver". Staff #4 stood C #2 hit Staff #4. Staff #4 instructed C#2 to sit down on the living room sofa.</p> <p>At 7:20 Staff #4 spoke to C #1 telling her to put back her medication box. Staff #4 then walked to the sofa where C#2 sat and administered antibiotic eye drops into C #2 eyes. Observed C #2 hit Staff #4 again. There was still no attempts made to call for outside help. Observed C #1 hit the Staff #5 and Staff #5 scream and take a jump back to avoid the hit.</p> <p>At 7:30 AM observed C #4 coming out of her room and C #1 chase C #4 who retreated back into her room. Later C #4 came back out of her room. Observed C #4 rubbing her face, pulling on her sweater. Observed C #1 standing still yelling in seal bark tones, shaking her arms. Observed Staff #4 seated at the medication desk reading medication for C #1.</p> <p>At 7:50 AM observed C #1 walk into the hallway nearest to the living room. Observed C #1 hit Staff #5. In response Staff #5 yelled and moved backward to avoid the hits, stating, "she doesn't like me". There was no attempt to calm the clients or call for assistance from outside of the home. Staff #5 went into the room of C#3 who had gone into her room on her own and Staff #5 could be heard saying, "Please, please need to take a shower."</p> <p>At 8:00 AM Staff #4 went into C #3's room and could be heard pleading with C #3 to take a shower for program. C#3 could be heard crying. C #2 fell asleep on the sofa. C #4 came out of her room and asked if she could open the front door. Staff #5 gave permission.</p>	9 277		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED PAGE</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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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
9 277	<p>Continued From page 14</p> <p>At 8:10 AM Staff #5 announced she was going to take C#4 to program and then go home, because her shift had ended. Staff #5 left the home with C #4 leaving Staff #4 with C#1, C #2, and C #3 in the home. By this time all clients had separated themselves on their own. C#1 and C#3 were in their rooms and C #2 was dozing on the sofa.</p> <p>Staff #5 stated this is the first time this has happened in the 2 years she has been working at the home. Staff #5 also stated C#2 is being isolated from program because of an eye infection and would be going to the Kwan Fong room located outside of the program room due to the infection.</p> <p>At 1:00 PM on the same day interviewed Staff #2. Staff #2 was asked about the training provided to manage clients who have behavior problems. Staff #2 stated: 3 things must be done. 1) Talk to the client; 2) Separate them with the first hit in a proper way, keep them busy. 3) Call for a reliever outside help. Staff #2 stated there was going to be an investigation on why the situation was not handled. Staff #2 stated that was a difficult home and that was why there is a reliever assigned to the home.</p> <p>At 1:48 PM on the same day interviewed Staff #1 regarding the behaviors observed in the home that morning. Staff #1 stated she was informed about the hitting. That Staff #4 said she was nervous and did not know what to do, if one hits they are told to go in the room but this morning all the clients except C #4 were hitting. Staff #1 stated there was going to be an incident report to write up.</p> <p>At 2:08 PM Staff #2 was informed that the survey was going to take out the Client Protection</p>	9 277		



Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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
9 277	<p>Continued From page 15</p> <p>Condition, become a full survey and an Immediate Jeopardy was being called. The clients were not being protected from each other, staff was not able to control the client behaviors, staff did not take measures to control the situation. Staff stated they were afraid. The facility was aware that this was a difficult home and had added a reliever staff in the morning however that reliever left one staff alone with the 3 clients who had been hitting and yelling when her shift ended. These factors warranted an Immediate jeopardy (IJ) situation.</p> <p>The facility abated the IJ that afternoon at 4:07 PM by submitting a Plan of Correction which included additional reliever in the afternoon from 3:30 PM to 7 PM. Additional reliever from 11:00 PM to 6:30 AM and 1 reliever from 6:00 AM to 8:00 AM to make 2 relievers in each shift plus the Home Manager. Training was to be provided that afternoon regarding the procedures in handling clients who are unruly hitting each other by redirecting/separating them from each other and calling other staff in the nearest homes. In service training was to be conducted by the Program Director weekly to all ORI Staff. And regular in-service training continued and as needed to ensure staff know the procedures in handling unruly clients in their respective houses.</p>	9 277		
9 279	<p>11-99-29(a)(10) RESIDENT'S RIGHTS</p> <p>Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to</p>	9 279		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  <b>AMENDED POC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <p style="text-align: center;">12G031</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <p style="text-align: center;">03/10/2017</p>
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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
9 279	Continued From page 16  the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall:  Be treated with consideration, respect and full recognition of their dignity and individuality, including privacy in treatment and in care. This Statute is not met as evidenced by: Based on observation, staff interview, the facility failed to ensure the rights of the client's privacy during treatment and care of personal needs.  Findings include:  On 03/09/2017 at 3:11 p.m., observation was made of Client #1 (CL1) and Client #4 (CL4) in bathroom together. CL#1 was brushing her hair and getting ready to shower when CL4 came into the bathroom, pulled down her pants and sat on the toilet to urinate. As a 3rd client was attempting to enter the bathroom, Staff #4 (S4) was able to redirect the third client.  Interview with Staff #4 at 03/09/2017 at 3:30 p.m. regarding the privacy of client. Staff#4 stated that they have tried to get clients to use "the other bathroom but we can't get them to follow". They all want to use the same bathroom. Staff #4 agreed that this does not provide privacy and should not be happening.	9 279	On 03/14/2017, The QIDP had an in-service training to the direct care staff and all caregivers on the protection of client rights and privacy for client #1 and client #4, during treatment and care of personal needs in the bathroom. All direct care staffs were reminded to follow the policies and procedures on each client protection and privacy rights in the home especially using the bathroom. Regular in-service training will be provided by the QIDP to all caregivers during Tuesday's weekly caregivers meeting and at least quarterly to ensure clients rights and privacy are properly implemented. The QIDP will continue to monitor direct care staffs in the house twice weekly from 3PM to 4PM to ensure training is properly implemented and the protection of client's rights and well-being is properly observed at all times.	3/14/17
9 285	11-99-29(a)(16) RESIDENT'S RIGHTS  Written policies regarding the rights and responsibilities of residents during their stay in the facility shall be established and shall be made	9 285		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED PCO</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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(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
9 285	<p>Continued From page 17</p> <p>available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall:</p> <p>Have daily visiting hours established. This Statute is not met as evidenced by: Based on record review and observations the facility staff did not demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>Cross Reference to W122 and W127</p> <p>Findings Include:</p> <p>On March 9, 2017 in the morning observed C#1, C#2, C#3 altercations between all three clients. In addition C#4 in the midst of the altercation appeared restless, retreating into her room then out lifting her sweater up to her chest and back down, rubbing her face. Record review of C #1's Positive Behavior Support Plan states, "If escalates to physical abuse towards other or herself, immediately direct her to an area away from the other clients. Provide supervision for safety. Minimize attention and conversation. Alert the Program Director." Review of C#2's Positive Behavior Support Plan includes, "If engages in verbal abuse and threats, recommended staff ignore, redirect and immediately direct her to stop" and "use a calm firm approach". Review of C #3's Individual Habilitation Plan states, "is usually happy, tends to be self-abusive, can be non-compliant and overly insistent." That afternoon at 1 PM</p>	9 285	<p>On 3/20/2017, the Psychologist Consultant assessed client #1, client #2 and client #3 behavioral outbursts, like crying, yelling, screaming, hitting each other and hitting staff on the day the DOH/OHCA monitors came last 3/9/2017 in the morning and recommended that a crisis plan will be made to ensure that aggressive active treatment training is provided in sufficient number and frequency. The QIDP had an in-service training to all direct care staff and ORI staffs regarding clients unaccepted behaviors and emphasized client's implementation of active treatment training program plans and Positive Behavior Support Plans on how to redirect each client using a calm firm approach, separating them from each other and asking help from other staffs in the nearest homes so that interventions are implemented consistently. Regular in-service training will be conducted to direct care staff and caregivers on the proper handling of clients who are unruly whenever there is a need and at least annually. The QIDP will continue to monitor all ORI staffs during Tuesday's weekly caregivers meeting to ensure that aggressive 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.</p>	3/20/17

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION <b>AMENDED PCC</b>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12G031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/10/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPPORTUNITIES AND RESOURCES, INC (HOL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786</b>
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9 285	<p>Continued From page 18</p> <p>interviewed Staff #1 regarding the staff inability to control the client situation in the home observed that morning. Staff #1 stated she spoke to Staff #4 and was told Staff #4 was nervous, and didn't know what to do anymore.</p> <p>Staff did not demonstrate skills in managing client behaviors that were stated in their behavior support plan.</p>	9 285		