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
	12G031		09/02/2021

NAME OF PROVIDER OR SUPPLIER

OPPORTUNITIES AND RESOURCES, INC (HOUSE 1-B

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 relicensing survey was conducted by the office of healthcare assurance (OHCA) on September 1, 2021. The facility met program requirements for Hawaii administrative rules, title 11, chapter 99 intermediate care facilities for the mentally retarded.	9 000		

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE