## PRINTED: 06/23/2023 FORM APPROVED

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:			(X3) DATE SURVEY COMPLETED	
		12G030	B. WING	B. WING		03/29/2021	
IAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE			
	NITIES AND RESOURCE	64-1510	KAMEHAMEHA HI	GHWAY			
	NINES AND RESOURCE	WAHIAW	VA, HI 96786				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES     ID       EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       EGULATORY OR LSC IDENTIFYING INFORMATION)     TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
9 000	INITIAL COMMENTS		9 000				
	of Health Care Assura	vas conducted by the Office ance (OHCA) on March 25 The census at the time of ents.					
9 085	11-99-9(c)(2) DIETET	IC SERVICES	9 085				
	Modified or therapeut be:	c diets shall					
	R1 from attaining the	et as evidenced by: , record reviews, and ailed to provide with a healthy snack					
	Findings include:						
	PM, R1 and R2 were table waiting for their passed out a Twinkie residents. Surveyor a residents were drinkir	sked the CG what the ig for their snack and she d R2 finished eating their					
	12:30 PM. R1's "Quai manager]/QIDP [Quai Professional] Progres	's chart done on 03/29/21 at terly CM [case ified Intellectual Disabilities s Report" for "November stated that R1 weighed 176					

WCN211

06/09/21

## PRINTED: 06/23/2023 FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assurance

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		12G030	B. WING	B. WING		/29/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
OPPORTU	NITIES AND RESOURCE	ES. INC (HOUSE 1-A	KAMEHAMEHA HI	GHWAY		
		WAHIAW	A, 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) COMPLET DATE
9 085	Continued From page 1		9 085			
	dated "July 10, 2020" under the dietitian's "RECOMMENDATION (sic) & GOALS" stated "Encourage only fruit and vegetables for snack Goal is for gradual wt (weight) loss or to maintain wt <175# (less than 175 pounds) over the next year."					
	12:50 PM, revealed th (high blood sugar). Hi Assessment" of "July dietitian's "RECOMMI "Recommend that ( carbohydrate diet (a p carbohydrates to main level), limit 2nd servin DM (diabetes mellitus high blood sugar) and "Health Maintenance Blood Sugar" includ	10, 2020" stated under the ENDATION (sic) & GOALS" (R2) continue a controlled prescribed amount of ntain a steady blood sugar logs and snacks to support s, a medical condition with				
	registered nurse (RN) R1 and R2 should hav and that the program	PM, an interview with the ) was done. She stated that ve had a healthier snack manager (PM) and CG buy for the home without any				
9 095	11-99-9(d)(3)(B) DIET	TETIC SERVICES	9 095			
	failed to ensure that F utensils to encourage	et as evidenced by: as and interviews, the facility R1 had the appropriate him to eat independently as we with his highest functional				

Office of Health Care Assurance STATE FORM

6899

WCN211

If continuation sheet 2 of 3

## PRINTED: 06/23/2023 FORM APPROVED

## of Hoalth Offic o of Hoalth C ц, nt .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED 03/29/2021	
	12G030				03		
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
OPPORTU	INITIES AND RESOURC	64-1510 64-1510	KAMEHAMEHA HI	GHWAY			
		WAHIAV	VA, HI 96786				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
9 095	Continued From page 2		9 095				
	continued dependence on his caregiver (CG) for assistance during meals and inhibits his ability to learn to eat on his own.						
	Finding includes:						
	R1 was made. R1 we the dining table. A Tw wrapper and placed front of him. A fork we into R1's right hand. handle of the fork and encapsulate his hand the handle to lift a por and bring to his mout made to use the fork and encouragement The CG then continu	d with hers to tightly grasp ortioned piece of the Twinkie th. One attempt by R1 was independently with cueing by his CG, but with difficulty. ied, hand over hand, to assist of his snack. R1's right hand					
	at 5:04 PM. His CG of feed himself. R1 fed assisted by the CG. side to make anothe resident and could so	of R1 was made on 03/25/21 encouraged R1 to try and himself slowly, occasionally The surveyor turned to the r observation of another ee from the corner of her eye s fork and fed him quickly.					
	CG was done. She v use regular utensils	D AM an interview with the vas queried if R1 was able to to eat independently and she se utensils to eat on his own, time."					
		wed on 03/29/21 at 2:45 PM. ad not tried any built-up m to eat independently					

WCN211