

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G042	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/13/2023
NAME OF PROVIDER OR SUPPLIER OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-C		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	<p>INITIAL COMMENTS</p> <p>A relicensing survey was conducted by the Office of Health Care Assurance from October 11-13, 2023.</p> <p>The facility was in compliance with Title 11, Chapter 99, Subchapter 1, Small Intermediate Care Facilities for Individuals with Intellectual Disabilities.</p> <p>Survey Census: 3</p>	9 000		

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE