STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G040	A. BUILDING _____ B. WING _____	04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-A)	**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) COMPLETION DATE
W 000	INITIAL COMMENTS A focused fundamental recertification survey was conducted by the office of healthcare assurance on April 12, 2024. The facility was found not in compliance with 42 CFR 440.150. survey dates: April 10 to April 12, 2024. Census: Four clients. Sample: Two clients.	W 000		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that one client (C)2 was free from verbal abuse by her caregiver while being reprimanded for bladder and bowel incontinence in the presence of other clients, caregiver, and the surveyor. The deficient practice was demeaning for the client and placed her at risk for psycho-social harm. Findings include: Home observation on 04/11/24 at 07:10 AM with the home manager (HM), caregiver (CG), C1, 2, 3, and 4 present in the dining/ living room. The surveyor was having a conversation with C2 about her upcoming activities at the day program. C2 mentioned that she was going to type on the computer, then turned toward the HM and stated, "I want my tablet." The HM responded to C2 in a	W 127		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 127	Continued From page 1 loud tone of voice saying I'll give you your tablet after you don't shishi (slang for urine) or dodo (slang for bowel movement) in your pants for one month. Then asked C2 did you make dodo in your pants last night? C2 appeared to look down toward the floor. The HM looked at the surveyor and said she's (C2) having a problem, I don't know, she's lazy to go to the bathroom. Interview on 04/12/24 at 10:45 AM with the quality intellectual disabilities professional (QIDP) and the registered nurse (RN). The surveyor discussed the conversation with the HM that took place on 04/11/24 in the morning during a home visit, when HM reprimanded C2 in a loud tone of voice in the presence of the other clients, caregiver, and surveyor because she was having bladder and bowel incontinence. The surveyor confirmed with both the QIDP and RN that the HM should not be speaking to C2 in a demeaning way in front of other people and that it was not acceptable. They confirmed that they were not aware of the behavior of the HM and that the tablet was being taken away from C2. Policy & Procedure for Abuse and neglect. Opportunities & resources, Inc. reviewed. III. Definitions 3. Psychological Abuse: Verbal or physical actions including threats, insults, or harassment that humiliate, provoke, intimidate, confuse, or frighten a client.	W 127		
W 286	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes.	W 286		

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W 286	Continued From page 2	W 286		

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure that restrictive interventions implemented by the home manager (HM) and used for discipline were not being used to manage the behavior for one client (C)2 of two in the sample. The HM confiscated C2s notebook as discipline for incidents of bowel and bladder incontinence. The deficient practice placed the client at risk for inappropriate use of restrictive interventions and psycho-social harm.

Findings include:

Cross reference W127 client protections.

Physician interview in the clinic at the wellness center on 04/10/24 at 11:13 AM. The Physician stated that C2 was having some bowel and bladder incontinence that started after she had knee surgery in August. The staff have her on a toileting schedule and are monitoring her. The incontinence started after she had surgery on her knee for a fractured patella (kneecap).

Home observation on 04/11/24 at 07:10 AM with the HM, caregiver (CG), C1, 2, 3, and 4 present in the dining/ living room. The surveyor was having a conversation with C2 about her upcoming activities at the day program. C2 mentioned that she was going to type on the computer, then turned toward the HM and stated, "I want my tablet." The HM responded to C2 in a loud tone of voice saying I'll give you your tablet after you don't shishi (slang for urine) or dodo (slang for bowel movement) in your pants for one month. Then asked C2 did you make dodo in your pants last night? C2 appeared to look down toward the floor. The HM looked at the surveyor

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W 286	Continued From page 3	W 286		

and said she's (C2) having a problem, I don't know, she's lazy to go to the bathroom. The surveyor asked HM where C2's tablet is? The HM said that she took the tablet from C2. I don't give it to her unless she doesn't make shishi in her pants or in her bed. The surveyor asked the HM if C2 is on a toileting schedule? HM said she's lazy to go to the bathroom. The surveyor asked her is this part of her treatment plan. The HM said yes. The surveyor asked the HM again, is C2 on a toileting schedule, do you take her to the bathroom? HM said I don't know when she's in the classroom, but she is lazy to go to the bathroom when she's here.

Day program observation in the classroom on 04/11/24 at 11:05 AM with day program teacher (DPT)1 and C3 who was sitting at a computer. The surveyor asked DPT1 if C2 has a tablet that she uses while in the day program or in the home. DPT1 said I don't think so, I don't remember seeing it in the classroom. C3 interjected "she got it taken away". At 11:30 AM observed C2 in the classroom with DPT2 present. The surveyor asked C2 where her tablet is. C2 responded my counselor took it. DPT2 prompted C2 and asked C2 why did she take it and to tell the surveyor, (to look at the surveyor instead of looking at DPT2). C2 stated so I don't shishi in my pants, I will not shishi in my pants ever again! DPT2 asked C2 why are you going shishi in your bed when your bathroom is right there in your room? C2 didn't respond and looked away from DPT2.

Record review. Annual Social work review November 16, 2023. C2 is a 60-year-old female. Her diagnosis includes mild mental retardation, diabetes mellitus type 2, anxiety, and depression.

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C2 has behavioral issues related to social skills, most prominent are making up stories and ordering others around. C2's Active treatment plan includes Washing/ Grooming (toileting, showering); Social Interaction (appropriate manners).

Plans & Approaches. 401 Toileting. Goal: By 07/2024, C2 will improve her toileting skills and hygiene, in 1 trial per day in each setting in 75 percent (%) of all trials for one calendar month. A plan for the management of bladder and bowel incontinence was not documented.

Psychiatrist noes dated 2/01/24, Medication management follow up. Staff reported that she has been incontinent of urine and stool, which began after her knee surgery and inability to get around. Sleep has been ok, and appetite is good. Plan: Will contact physician for incontinence to determine if any work up is necessary return to clinic 03/01/24 praised for success.

Psychiatrist notes dated 03/01/24, C2 stated "I shishi at night, I wish I could take something to control the shishi". Staff noted a lot of cleanups necessary and that she showers 2 times/ day. Assessment: Frequent incontinence of urine, mostly at night but in daytime too. She's been doing well in the program otherwise. Plan to follow up with physician for incontinence. Message left & await call back.

Interview on 04/12/24 at 10:45 AM with the quality intellectual disabilities professional (QIDP) and the registered nurse (RN). Surveyor asked about the incontinence C2 started having in August and if there was any follow up with the physician or the treatment plan. The QIDP stated that the

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W 286	Continued From page 5 physician wants us to observe her for her incontinence for now. The surveyor asked if there is a toileting schedule in place. The QIDP stated I think it was just pending on the condition of the knee. He said to just take her to the bathroom prior to bedtime. The surveyor discussed the conversation with the HM that took place on 04/11/24 in the morning during a home visit. The surveyor asked if they were aware that C2's tablet was being taken away from her by the HM for wetting the bed or her pants, they said "no". When asked if the tablet is being taken away was part of C2's active treatment plan. They said no. When asked if confiscation of C2's tablet for the management of her behavior should be included in part of the active treatment plan, they said yes. The surveyor asked if the interdisciplinary team and behavior management committee would be required to review this type of intervention on the behavior plan and they said yes. Policy & Procedures for behavior management plan. Opportunities & resources Inc. Revised 03/21/23. II. Policy 11. Unplanned or impromptu interventions to control behaviors which have not been specifically addressed in a clients behavior management plan (BMP) shall be prohitbited.	W 286		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications as ordered by the physician for two	W 368		

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W 368	Continued From page 6 of four clients in the sample. The home manager (HM) administered the wrong medication to two clients (C)2 and C3 and did not document the medication was given; and administered a medication to C2 at the wrong time. The deficient practice places the clients residing in the home at an increased risk for injury. Findings include: Home observation on 04/10/24 at 3:00 PM. The HM went to the medication closet and removed two tubes of ointment (hydrocortisone cream) and one box containing a tube of ointment (triple antibiotic ointment) labeled with C1's name, and cotton swabs and placed the items on the desk in the dining room. The HM put ointment on a cotton swab and went into C3's room, to apply ointment on her neck. When the surveyor asked why she was putting the medicine on C3s neck, the HM responded that she has scratches that she got after she got a haircut. A few minutes later the HM was observed to remove a band aid from C2's upper back and apply ointment from the same tube then replaced a new band aid. After she finished, she put the ointment back into the closet. The surveyor asked the HM why she put the ointment for C1 on C2 and C3 and she said, no it was not C1's antibiotic ointment, it was C3s. The surveyor reviewed the medication log for C2 and C3. C2 had a physician order for antibiotic ointment; apply topically two times per day as needed for minor cuts/scratches. C3 had a physician order for triple antibiotic ointment; apply topically two times per day as needed for minor cuts/ scratches. No documentation was found on the medication logs that the ointment was given for C2 or C3.	W 368		

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W 368	Continued From page 7 2) Home observation on 04/10/24 at 3:00 PM. The HM was administering the following medications to C2: Glipizide (a medication to regulate blood sugar) 10 milligram (mg) Tablet. Take two tablets by mouth two times per day 30 minutes before meals (4:00 PM) and Metformin (a medication to regulate blood sugar) 1000 mg tablet. Take one tablet by mouth two times per day with meals (4:30 PM). The HM poured the Glipizide into the medication cup then poured the metformin into the cup. The surveyor asked the HM if the metformin was supposed to be given at that time or with the meal? The HM stated it is given before meals. The surveyor pointed to the orders written on C2's medication log that stated give with meals. The HM took the metformin pill out of the medication cup and put it back in the labeled container. When the HM asked C2 to take the medications, she looked at the HM and said where is the other pill? I'm supposed to take three pills. The HM said I will give it to you later. Dinner was served at 5:00 PM and the HM was not observed to give the metformin to C2. The surveyor reviewed the medication log at 6:00 PM and noted the metformin was documented as given by the HM and also noted the metformin was documented on C2s medication log that it was given at 4:30 PM from 04/01/24 to 04/10/24. The HM discussed with the surveyor that the medication time for the metformin is written on the medication log to be given at 4:30 PM and that the dinner meal is not served until 5:00 PM, and she is confused. She asked if the surveyor talk to the nurse since she is the one who writes out the instructions on the medication log? The HM confirmed that she did not give the metformin to C2 with dinner because she was confused and would give it later. During the medication	W 368		

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W 368	Continued From page 8 administration observation at 6:30 PM the HM gave the metformin to C2. Registered Nurse (RN) interviewed on 04/11/24 at 10:05 AM in the wellness center conference room. The surveyor discussed the observation in the home on the previous day when the HM administered the wrong medication that was ordered for C1 to C2 and C3, and it was not documented on the medication log after it was administered; and the metformin was given to C2 at the wrong time, that it was ordered by the physician to be given with dinner but it had been given 30 minutes before dinner instead. The RN verified that all medications should be given per the physician orders and checked to make sure the right medication is being given to the right client, at the right time and documented accurately on the medication log. The RN stated the HM recently attended training on medication administration procedures. Medication Administration opportunities and resources, INC. reviewed. Goals and objectives ... Correctly prepare, and safely administer ...oral meds ...topical meds ...eight rights of medication administration right medication ...right Client ...right dose ...right time ...right documentation ...If no record = it didn't happen ...record it immediately ...documentation includes name, dose, route, exact time of administration ... Basic Health and safety medication administration training log reviewed dated 02/27/24, noted the HM participated in the training.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2)	W 382		

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W 382	Continued From page 9 The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation, interview and policy review the facility failed to keep the medication cabinet locked. The home manager (HM) left the medication closet door unlocked prior to and during administration of medications to two clients. The deficient practice compromises the safety of all residents in the home. Findings include: Home observation on 04/10/24 at 3:37 PM in the dining room. Noted the medication closet door with hasp closed and padlock hanging loosely from the door unlocked. A sign was posted on the closet door that read "keep locked." Observed a lanyard with a set of keys on it laying on a bookshelf in the hall near the closet. Clients (C)2 and C3 were sitting in the living/dining room with the home manager (HM). At 4:00 PM the HM went to the medication cabinet and opened the unlocked medication door. The surveyor asked, do you usually lock the medication cabinet? The HM stated "I opened it when I got the medicine out earlier. The HM took the medication container from the cabinet for C3 leaving the cabinet door open. The HM continued to administer medication to C3 at the desk in the dining room with her back facing the cabinet that was a few yards away. When the HM finished administering the medications and put C3's medication box back in the closet, she removed C2's box to administer C2's medications. After the medications were administered, the HM returned C2's medication	W 382		

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W 382	Continued From page 10 box to the closet. The surveyor discussed with the HM that the medication cabinet was left unlocked prior to and during the medication administrations for both C2 and C3 and verified that she had forgotten to lock it after administering the medication earlier in the afternoon and that it should be kept locked. Registered Nurse (RN) interview on 04/11/24 at 10:05 AM in the wellness center conference room. The surveyor discussed the observation in the home on the previous day when the medication closet was found unlocked prior to and during the administration of medications. The RN verified that the medication closet should always be locked unless the staff are taking the medications out to administer to the clients. Storage and handling of drugs, opportunities & Resources, Inc. revised 11/29/22 reviewed. B. 1. Drugs shall be stored under proper conditions of sanitation ...and security in accordance with ICF/IID Regulations (Chapter 99). 2. All drugs shall be kept under lock and key except when authorized personnel are in attendance. No unauthorized persons shall have access to storage cabinets or areas.	W 382		