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	(X3) DATE SURVEY COMPLETED
	12G042	A. BUILDING: ______ B. WING ______	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-C	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 licensure survey was conducted by the State Agency from 09/02/25 through 09/04/25. The facility was found not to be in compliance with Title 11, Chapter 99, Intermediate Care Facilities for Individuals with Intellectual Disabilities.	9 000		
9 004	11-99-3(j) LICENSING PROCEDURE The current license shall be posted in a conspicuous place, visible to the public, within the facility. This Statute is not met as evidenced by: Based on observation and interview, the facility failed to ensure the current license was posted in a conspicuous place visible to the public within the facility. This deficient practice makes it unclear to client visitors if the facility is a licensed operator/supplier of services. Findings include: On 09/02/25 at 03:30 PM, during a tour of the home, observed that the facility license posted was issued in 2021. A current license was not found posted anywhere in the home. On 09/04/25 at 11:00 AM, during a tour of the Administrative Offices, observed no posting of the facility's current license(s). On 09/04/25 at 11:12 AM, an interview was done with the Program Coordinator (PC). Asked to see a copy of the home's current license. Current license was found in a binder in the PC's office. PC confirmed that a copy of the current license should be posted in the home.	9 004		

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

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9 005	Continued From page 1	9 005		
9 005	11-99-4(a) ACTIVE TREATMENT PROGRAM	9 005		

A plan of treatment shall be developed and implemented for each resident in order to help the residents function at their greatest physical, intellectual, social, emotional, and vocational level.
This Statute is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to maintain a continuous active treatment program, which includes aggressive, consistent implementation of a program which is directed toward the prevention or deceleration of regression or loss of functional status for 2 of 3 clients (Clients (C)1 and 2) sampled. This deficient practice places the clients at risk for failure to progress, and/or lose skills.

Findings include:

1) Client (C)2 is a 55-year-old male admitted to the facility on 07/29/05 with diagnoses that include, but are not limited to, moderate intellectual disability and Diabetes.

A review of C2's Active Treatment (AT) Program noted the following programs, last reviewed 06/17/25: Toileting, Showering, Vocational and Self-Direction, and a Positive Behavior Support Plan to address C2's identified behaviors of teasing others and making inappropriate comments to others. A review of the most recent Case Manager (CM) assessment available, an Annual CM Progress Report, documented on 06/17/25 by CM3, revealed the following regarding C2's progress:

"He [C2] still needs assistance in his toileting, showering ..."

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9 005	Continued From page 2 "He needs more encouragement with the help of his caregivers and all the staffs ... by providing opportunities to be preoccupied with leisure activities, setting behavioral expectations with unfamiliar people, and refrain from reinforcing the target with attention ..." On 09/02/25 from 10:50 AM to 11:30 AM observed C2 from the Day Program classroom to the dining hall for lunch with no staff supervision, direction, instruction, or correction. At one point, C2 left the classroom and walked to the dining hall to get himself some iced tea without staff in the classroom aware that he was gone. On 09/02/25 at 11:40 AM, while in the dining hall standing in line for lunch, observed C2 tell C4 to "shut up" even though C4 was speaking to someone else at the time. Teacher (T)1 and T2 were present at the time, however no correction or redirection was made. On 09/02/25 at 12:12 PM, while C2 was back in the classroom area following lunch, up in the front with no staff supervision, observed C4 walk up to the front area and without provocation, C2 immediately made the following comments towards and about her: "Fat pig... she is ugly ..." On 09/02/25 at 12:21 PM, observed C2 coming out of the bathroom with C4 walking down the hallway towards the front. C2 commented to her "Shut up, ugly monkey, don't talk to me ever." C4 was not talking to anyone or attempting to talk to anyone at the time. T1 and T2 happened to walk by with another client, yet no correction was made or redirection attempted. Both C2 and C4 were ignored.	9 005		

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9 005	Continued From page 3	9 005		

On 09/02/25 at 12:27 PM, T1 told C2 to "move to the back with everyone else." C2 moved into the Sunflower Room where T1 left him. No AT was suggested or initiated. C2 remained in the Sunflower Room until 01:30 PM with 5 other clients, all watching television, with no AT or supervision.

On 09/02/25 from 02:30 PM to 06:00 PM observations were made of C2 in the home, during which time he used the bathroom multiple times and showered. No observation was made of any supervision or direction of his washing/grooming activities, nor of any vocational skills or self-direction AT programs being implemented. C2 was not encouraged or asked to complete/assist in any activity beyond carrying his dinner plate from the kitchen counter to the table (and after eating, to the kitchen sink), and carrying the trash that the Caregiver (CG) had gathered out to the trash bin.

Similar observations were made in the home on 09/03/25 from 04:43 AM to 07:00 AM, during which time C2 went to the bathroom, shaved, and showered. No supervision, direction, or AT implemented beyond carrying his dirty dishes to the kitchen sink and carrying out the trash that CG had gathered from the home.

On 09/04/25 at 01:59 PM, an interview was done with CM2. CM2 stated she visits the classroom 3 to 4 times a week and visits the home every day. When discussing C2's treatment of and inappropriate comments to C4, CM2 confirmed that staff are aware of C2's behavior targeting C4, stating, "everyone knows he [C2] hates her [C4]." CM2 also confirmed that C2's AT program should be consistently implemented in the classroom and in the home.

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9 005	Continued From page 4	9 005		

2) Client (C) 1 is a 55-year-old male initially admitted to the facility on 07/31/89 with diagnoses that include, but are not limited to, moderate intellectual disability and Down's Syndrome.

A review of the Plans and Approaches for C1's Active Treatment Program for Vocational and Self Direction, with a start date of 06/01/24, noted the following:
- Goal: "Increase his ability to stay on task and follow directions in order to improve sense of independence in his activities of daily living."
- Steps: "7. To squeeze the water out of the mop with 1 verbal cue."
- Frequency of Training: 1 trial per day.

On 09/02/25 at 12:20 PM, observed C1 filling the mop bucket with water outside of the dining area after lunch. Teacher (T) 2 passed by and proceeded to turn off the water and stated to C1 that the mopping was already done. T2 then asked another client to put away the mop and empty the mop bucket water and instructed C1 to return to the classroom, which did not allow C1 to participate in his vocational training program.

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9 108	11-99-11(c)(1) RESIDENT DAILY LIVING CARE AND TRAINING	9 108		

The facility staff shall provide at least the following:

Supportive services to enable residents to participate fully in appropriate daily activities.
This Statute is not met as evidenced by:
Based on observation and interview, the facility failed to promote the growth, development, and

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9 108	Continued From page 5 independence of 1 of 3 clients (C)2 sampled by not utilizing all opportunities to teach and reinforce skills and not encouraging him to complete tasks with as much independence as possible. This deficient practice places the client at risk for failure to progress and a decreased quality of life. Findings include: Client (C)2 is a 55-year-old male admitted to the facility on 07/29/05 with diagnoses that include, but are not limited to, moderate intellectual disability and Diabetes. C2 is ambulatory and requires no assistive devices to perform his activities of daily living. On 09/02/25, observations were made in the home. At 04:56 PM, C2 had just returned back to the home after walking with Caregiver (CG) to pick up dinner. As soon as he was back, C2 sat at the dining table while Teacher (T)1 began portioning out all the food (BBQ meatballs, rice, toss salad, peaches) onto plates for the clients. T1 did not try to engage him or any other client to assist with serving food, making plates, or cleaning the dining table to prepare for dinner. At 05:01 PM, T1 called C2 into the kitchen where she was making the plates and instructed him to carry his own plate to the dining table. C2 was not reminded or directed to wash his hands. At 05:09 PM, C2 was observed feeding himself his dinner using regular utensils without difficulty. At 05:29 PM, T1 was observed washing all the dinner dishes without attempting to engage any clients in assisting.	9 108		

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9 108	Continued From page 6 At 05:30 PM, T1 was observed wiping the dining table without attempting to engage any clients in assisting. At 05:31 PM, T1 was observed sweeping under and around the dining table without attempting to engage any clients in assisting. On 09/03/25 at 05:31 AM, observed the clients in the home eating breakfast. None of the clients were encouraged or even allowed to serve themselves or get their own drinks. On 09/04/25 at 01:59 PM, an interview was done with Case Manager (CM)2. While discussing the clients of the home, CM2 agreed that all the clients could and should be encouraged to be more independent with tasks. CM2 also agreed that C2, with guidance, should be able to rinse his own dishes, wipe the table, or sweep the floor.	9 108		
9 138	11-99-13(2)(G) GOVERNING BODY AND MANAGEMENT There shall be documented evidence that every employee has a pre-employment and an annual health evaluation by a physician. These evaluations shall be specifically oriented to determine the absence of any infectious disease. Each examination shall include a tuberculin skin test, as defined, or a chest x-ray. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide documented evidence that every employee had an annual tuberculin (TB) skin test, as evidenced by an overdue TB test for Reliever	9 138		

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9 138	Continued From page 7 (R)1. As a result of this deficient practice, the absence of any infectious disease(s) could not be confirmed. Findings include: Review of the Employee Health Worksheet noted that R1's last documented "TB Test" was on 08/08/24, making it overdue since 08/08/25. On 09/04/25 at 10:50 AM, interview with the Program Coordinator (PC) confirmed that R1's TB test was overdue and needed to be updated.	9 138		
9 168	11-99-18(f) LIFE SAFETY All employees shall be instructed and kept informed respecting their duties under the fire and disaster programs. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure all personnel were trained to perform assigned tasks in relation to quickly evacuating the clients from the home in an emergency. This deficient practice places the clients at risk for preventable injuries and/or harm in the event of an emergency requiring immediate evacuation from the home. Findings include: On 09/02/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The Clients (C) of the home include three individuals with intellectual disabilities, one profound, and two moderate. On 09/03/25 at 02:50 PM, an interview was done	9 168		

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9 168	Continued From page 8	9 168		

with the Caregiver (CG) of the home. When asked about evacuation drills in case of an emergency such as a fire, CG initially answered that she did not know anything about them. After some thought, however, CG displayed an empty black bag she took out of Client (C)3's closet that she explained is normally filled with clothes which she had recently removed for washing. CG stated that each client in the home had a bag of clothes prepared, and if they needed to evacuate, she would grab each bag before assisting the clients out of the home. Confirmed again with CG that if it were a fire, and she needed to get the clients out of the house to safety quickly, she would grab the bags of clothes first. When asked if she would take anything else with her before evacuating, CG answered "no."

On 09/04/25 at 08:30 AM, an interview was done with the Program Coordinator (PC). PC confirmed that she is responsible for the facility's Emergency Preparedness Program. When discussing evacuation drills and training, PC confirmed that no one observes the evacuation drills to ensure that it is being conducted correctly. PC agreed that if there were a fire and the home needed to be evacuated, she would not want staff to waste time grabbing bags of clothes for the clients, but to ensure their bodily safety first.

Review of the facility's Policies & Procedure for Disasters and Emergency Situations, last reviewed 04/04/25, revealed that in the event of a fire clients "will leave in an orderly fashion ..." assisted by program staff. The policy is noted to not include grabbing anything before ensuring the clients immediate evacuation.

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9 171	Continued From page 9	9 171		
9 171	11-99-19(b) MAINTENANCE There shall be records that document compliance with environmental safety codes of the state and county authorities having primary jurisdiction over the facility. Inspection of all devices essential to health and safety of residents and personnel shall be carried out daily or at sufficiently frequent intervals to ensure proper operational performance. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of seven smoke detectors checked in the home were operational. As a result of this deficient practice, the safety of the clients and staff was jeopardized in the event of a fire in the home. Findings include: On 09/03/25 at 06:10 AM, seven smoke detectors in the home were checked. Five smoke detectors had a green light illuminating from the cover of the detector. Two detectors, one above the main entrance door and one on the ceiling in an unoccupied client room, had no green light illuminating. Caregiver (CG) stated that she did not know what the green illuminating light on the detector meant and if it had anything to do with the functioning of the detectors. She also stated that Maintenance checks the detectors monthly. A review of a sheet posted in the home titled, "Check List Log Smoke Detector/Alarm Check/Fire Extinguisher (Monthly)" revealed it had 07/31/25 02:00 PM as the last documented date the check was completed by Maintenance	9 171		

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9 171	Continued From page 10 staff. On 09/03/25 at 01:58 PM, Maintenance (M) 1 was interviewed, and verified that a green light illuminating on the detector means that it is working. No green light means it is not functioning. On 09/04/25 at 01:00 PM, during an interview with M1, he confirmed that he checks the smoke detectors in the home once a month, and stated that he "forgot" to write the August date on the Smoke Detector/Alarm Check/Fire Extinguisher Check List Log. M1 was unable to produce any other documentation to show that he had completed the August check.	9 171		
9 176	11-99-20(c)(2) NURSING SERVICES In facilities with residents requiring nursing services, the following additional care shall be provided: Restorative and preventive nursing care including resident education for each resident. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to provide periodic surveillance of the health status of Client (C) 1 as evidenced by a fungal infection treatment listed on the 90-day physician order update, dated 01/31/23, up to the most recent physician order update, dated 07/31/25, with no evaluation of effectiveness, re-evaluation of need, and/or documentation of follow-up by C1's physician or dermatologist. This deficient practice did not assure an optimal level of wellness for C1.	9 176		

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9 176	Continued From page 11	9 176		

Findings include:

On 09/02/25 at 03:02 PM, an order for Econazole Nitrate 1% cream, apply to affected area 2 times a day for fungal infection was noted on C1's September 1-15, 2025, Medication Administration Record (MAR) and signed off by caregiver as being given at 05:00 AM on 09/01/25 and 09/02/25 and at 05:00 PM on 09/01/25.

On 09/04/25 at 09:30 AM, interviewed the Registered Nurse (RN) regarding the order for Econazole Nitrate 1% cream with concurrent review and confirmation of information on the following documents:
- 90-day physician order update dated 01/31/23 listed order for Econazole Nitrate 1% cream. Apply to affected areas 2 times a day for fungal infection.
- 90-day physician order update dated 07/31/25 continued with order for Econazole Nitrate 1% cream. Apply to affected areas 2 times a day for fungal infection.
- Most recent Dermatologist note on file dated 08/07/15.
- Nurse's Quarterly Physical Assessment and Summary covering 03/01/25 to 05/31/25 documented, "Skin: Intact, with no visible lesions or abnormalities."
- Physical Examination Report conducted by Nurse Practitioner (NP) on 07/24/25, documented, "Skin/Hair: Normal."

RN stated a follow-up appointment should have been made with the dermatologist and a follow-up should have been done to evaluate the effectiveness and need for the Econazole cream.

A review of the facility's Health Maintenance Plan for C1, with a review date of 08/05/25, listed

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9 176	Continued From page 12 "Fungal Infection" under the "Problem/Need/Concern" area and stated, "4. Assess, record and report any changes in skin status to CM [Case Manager] and PMD [Primary Medical Doctor]." A review of the facility's policy titled, Instructions for Nursing Assessment, last revised 11/29/22, noted, "Nursing Assessment shall be completed by the Registered Nurse upon admission and annually ...Medication/Treatment Adjustment during Assessment Period ...Document effects of medication/treatment ...throughout the last 12 months." On 09/04/25 at 11:06 AM, RN stated that she does quarterly physical assessments but does not review the clients' medication list(s).	9 176		
9 194	11-99-22(g)(1) PHARMACEUTICAL SERVICES All drugs shall be kept under lock and key except when authorized personnel are in attendance. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to keep all drugs and biologicals locked except when being prepared for administration. This deficient practice left medications accessible to 3 of 3 Clients (C) in the home. Findings include: On 09/02/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The Clients (C) of the home include three individuals with intellectual disabilities, one profound, and two moderate. The three Clients are all independently ambulatory and roam around the house at-will.	9 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-C	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
9 194	Continued From page 13 1) Observations made in the Home on 09/03/25 from 04:43 AM to 06:30 AM noted the medication closet consistently left unlocked as Caregiver (CG) conducted morning care and tasks, including medication administration. On 09/03/25 at 05:52 AM, an interview was done with CG. CG confirmed the medication closet was unlocked first thing in the morning at 04:30 AM so that she could get the clients' topicals out for them as they showered, and the closet stays unlocked until she is done passing medications (currently unlocked). Observations confirmed that the medication closet was not locked until 06:30 AM when all medications had been administered. On 09/04/25 at 08:57 AM, an interview was done with Registered Nurse (RN)1. RN1 confirmed the medication closet should be locked when not in use between clients. Agreed it is not acceptable to leave medication closet unlocked all morning as medications are prepared and given. Review of the facility's policy and procedure, Storage and Handling of Drugs, last revised 11/29/22, revealed the following: "All drugs shall be kept under lock and key ... No unauthorized persons shall have access to storage cabinets or areas ... Cabinets and shelves shall be appropriately labeled and locked." 2) On 09/02/25 at 05:45 PM, Caregiver (CG) brought client's (C) 1 medication storage container to the table in the living room. The medication cabinet was left unlocked while unattended. On 09/03/25 at 05:55 AM, CG brought C1's medication storage container to the	9 194		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G042	A. BUILDING: ______ B. WING ______	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-C	**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
9 194	Continued From page 14 table in the living room and the medication cabinet was left unlocked while unattended. After assisting C1 with his medication, CG returned the medication container to the medication cabinet, closed the latch on the door, placed the pad lock over the latch, but did not lock it before walking away from the cabinet.	9 194		