

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/13/2025
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NAME OF PROVIDER OR SUPPLIER OPPORTUNITIES AND RESOURCES, INC (HOUSE 1-A	STREET ADDRESS, CITY, STATE, ZIP CODE 64-1510 KAMEHAMEHA HIGHWAY WAHIAWA, HI 96786
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(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 follow up desk review was conducted by the Office of Healthcare Assurance on April 24, 2025. The citations from the relicensing surveyor on January 16, 2025, were corrected. Recommend relicensure.</p>	{9 000}		

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