| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G040 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/20/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-A)** | **64-1510 KAMEHAMEHA HIGHWAY , WAHIAWA, Hawaii, 96786** |

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| E0000 | Initial Comments<br><br>A recertification survey was conducted by the Office of Health Care Assurance on March 20, 2025. The facility was found not to be in substantial compliance with the requirements at §483.475, Emergency Preparedness. | E0000 | | |
| W0000 | INITIAL COMMENTS<br><br>A focused fundamental recertification survey was conducted by the Office of Health Care Assurance on 03/20/25. The facility was found not to be in substantial compliance with the requirements of 42 CFR 483, Subpart I, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).<br><br>Survey Dates: 03/18/25 to 03/20/25<br><br>Census: 4 clients<br><br>Sample: 2 clients | W0000 | | |
| W0108 | COMPLIANCE W FEDERAL, STATE & LOCAL LAWS<br><br>CFR(s): 483.410(b)<br><br>The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to safety, and<br><br>This STANDARD is NOT MET as evidenced by:<br><br>§11-99-14 Housekeeping. (h) Sufficient locked storage areas shall be<br><br>provided for all cleaning materials and equipment.<br><br>Based on observations, interviews, and record review, the facility failed to comply with Hawaii Administrative Rule, Chapter 99, §11-99-14(h), as evidenced by observations of caustic cleaning materials kept on the closet floor of an unlocked and | W0108 | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| W0108 | Continued from page 1<br>unoccupied room in the home. This area was accessible to three of four clients in the home.<br><br>Findings include:<br><br>1) On 03/18/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The clients (C) of the home include four individuals with intellectual disabilities, one profound, and three mild. The three clients with mild intellectual disabilities are independently ambulatory and freely move about their home as they please .<br><br>On 03/18/25 at 03:40 PM, observation was made, and concurrent interview was done with Staff (S)1 in an unoccupied bedroom S1 identified as the Caregiver's Room. On the floor of the open closet in the unlocked room was a large bottle of bleach and a spray bottle of cleaning/disinfectant spray. When asked, S1 stated that the room was kept locked, however, she did not lock the room as we exited. The SA confirmed that up until leaving the home at 07:30 PM that evening, the Caregiver's Room remained unlocked.<br><br>Observations in the home done on 03/19/25 from 05:00 AM to 07:15 AM confirmed that the Caregiver's Room was unlocked and remained unlocked the entire time.<br><br>Review of the facility's undated Hazardous Chemical Policy revealed the following:<br><br>"Hazardous or toxic materials shall be stored in a locked cabinet ..."<br><br>2) On 03/18/25 at 03:01 PM, observed a bucket on the floor of the laundry area in the client's residence. The bucket was labelled, "Laundry Detergent" and the top was covered but not secured. Cover was lifted and revealed the bucket contained a white powdered substance. S4 identified the powdered substance as laundry detergent. When asked if the laundry detergent should be placed in a secured location, S4 said they do not lock it up and just leave it in the laundry area.<br><br>On 03/19/25 at 03:21 PM, an interview was | W0108 | | |

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| W0108 | Continued from page 2<br>conducted with the Program Manager (PM) in the conference room. PM confirmed that the laundry detergent is to be secured and locked with the other cleaning supplies. | W0108 | | |
| W0130 | PROTECTION OF CLIENTS RIGHTS<br><br>CFR(s): 483.420(a)(7)<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observations and interview, the facility failed to ensure personal privacy was provided for one of four clients (Client (C)1) during treatment and care of her personal needs. This deficient practice placed C1 at risk for embarrassment and shame.<br><br>Findings include:<br><br>On 03/18/25 at 02:50 PM, observation was done in the Home of Staff (S)4 assisting Client (C)1 to the restroom. The State Agency (SA) team consisted of one male and one female surveyor that had followed S4 and four clients from the Day Program to the home. The SA made observation of C1 sitting on the toilet bare below the waist, S4 was assisting her, and the bathroom door was left wide open. At 02:53 PM, observed C1 with all her clothes off in the bathroom, as S4 was assisting her to get into the shower. At this time, observed S4 close the bathroom door for privacy.<br><br>On 03/18/25 at 03:05 PM, an interview was done with S4. S4 confirmed that the bathroom door should have been closed earlier to maintain C1's privacy while on the toilet and while undressing for her shower. | W0130 | | |
| W0196 | ACTIVE TREATMENT<br><br>CFR(s): 483.440(a)(1)<br><br>Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: | W0196 | | |

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| W0196 | Continued from page 3<br>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and<br><br>(ii) The prevention or deceleration of regression or loss of current optimal functional status.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observations, 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 one of four clients (Client (C)1). This deficient practice places the client at risk for failure to progress, and/or lose skills.<br><br>Findings include:<br><br>C1 is a 57-year-old female admitted to the facility on 10/20/04 with diagnoses that include, but are not limited to, profound intellectual disability, epilepsy, autism, dysarthria (difficulty speaking because the muscles you use for speech are weak), and congenital scoliosis (a sideways curvature of the spine).<br><br>A review of C1's Active Treatment (AT) Program noted the following program to address C1's dysarthria/communication needs, last reviewed 05/01/24:<br><br>"Expressive Language ... will learn to sign for common words using Modified Sign Language."<br><br>A review of the Plans & Approaches for the Expressive Language Program, dated 05/01/24, noted the frequency of training should include two trials in the Day Program (DP) and two trials in the Home, every day. The Modified Sign Language includes signs for sleeping, hungry, feel sick, and thirsty. Documented on the bottom of the Plans & Approaches are two Staff (Staff (S)1 and S6) who were trained on 04/22/24 by the Case Manager (CM) in the Modified Sign Language to be used with C1.<br><br>Observations were done both in the Day Program/Classroom and in the home on 03/18/25 | W0196 | | |

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| W0196 | Continued from page 4<br>from 11:00 AM to 07:30 PM, and 03/19/25 from 05:10 AM to 07:40 AM. At no time was anyone observed attempting to communicate with C1 using her Expressive Language program.<br><br>On 03/20/25 at 02:13 PM, an interview was done with CM in the Conference Room. CM confirmed that only two staff members had been trained on the Modified Sign Language to use with C1, and one of them (S6) had retired in December 2024. CM also confirmed that the Modified Sign Language to be used with C1 was different from American Sign Language. CM acknowledged that with only one current staff member trained in the Modified Sign Language, it would be difficult to consistently implement this aspect of C1's AT Program. | W0196 | | |
| W0331 | NURSING SERVICES<br><br>CFR(s): 483.460(c)<br><br>The facility must provide clients with nursing services in accordance with their needs.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure the provision of nursing services met the client's needs for one of two clients (Client (C)1) in the active sample as evidenced by unexplained and unintended weight loss that was not addressed in C1's Health Maintenance Plan (HMP). This deficient practice places C1 at risk for physical and functional decline.<br><br>Findings include:<br><br>C1 is a 57-year-old female admitted to the facility on 10/20/04 with diagnoses that include, but are not limited to, profound intellectual disability, epilepsy, autism, dysarthria (difficulty speaking because the muscles you use for speech are weak), and congenital scoliosis (a sideways curvature of the spine).<br><br>A review of C1's Monthly Weight Chart noted that between June and September 2024, C1 lost 10 pounds (going from 160 to 150 pounds), reflecting a 6.2% weight loss in three months. For the next three months, C1 maintained her weight at 150 pounds. Between December 2024 and March 2025 however, C1 lost 9 pounds, going down to 141 pounds, | W0331 | | |

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| W0331 | Continued from page 5<br>reflecting another 6% weight loss in three months.<br><br>A review of C1's Health Maintenance Plan, last reviewed on 02/17/25, revealed nothing to address that an unexplained weight loss trend had been identified.<br><br>A review of the Physician's Progress Orders/Notes from a follow-up visit with her psychiatrist on 03/05/25 revealed the first documentation identifying that C1's weight loss trend needed to be addressed and included the following:<br><br>"She's lost 9 # [pounds] since we met in Dec [December] ... more thin appearing than I have seen her ..." with the psychiatrist making a referral to C1's "PCP [primary care physician] re: [regarding] wt [weight] loss."<br><br>On 03/20/25 at 10:08 AM, an interview was done with the Registered Nurse (RN)1. RN1 stated that she did review the monthly weight chart every month, and had noticed C1's weight loss, but missed that it was trending towards a significant weight loss. RN1 acknowledged that had she noticed, she would have made a referral to the Registered Dietician (RD) consultant and asked the PCP for additional laboratory tests, and possibly an order for a nutritional supplement. | W0331 | | |
| W0341 | NURSING SERVICES<br><br>CFR(s): 483.460(c)(5)(ii)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to ensure staff followed infection control practice while assisting one of four clients (Client (C)2) residing in the home. This deficient practice places the clients at increased risk for preventable illnesses or infections. | W0341 | | |

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| W0341 | Continued from page 6<br>Findings include:<br><br>On 03/18/25 at 03:22 PM, observations made in the client's residence with Staff (S)1 and S4 providing care after C2 returned from the classroom. C2 came out of the bathroom and was asking S4 for her mouthwash. S4 was assisting another client so C2 asked S1 for assistance. S1 just finished assisting C4 in the bathroom and was still wearing gloves. When C2 asked S1 for her mouthwash, S1 removed her glove and clenched it in her right hand as she opened a drawer to get a set of keys. S1 then proceeded to unlock the supplies cabinet and looked for C2's mouthwash. S1 then gave C2 her mouthwash while still holding the used glove in her right hand. S1 then entered another client's room to check on her, came out immediately, and was no longer holding the used glove.<br><br>On 03/20/25 at 10:52 AM, an interview was conducted with Registered Nurse (RN)1 in the conference room. Shared observation of S1 not performing hand hygiene after removing gloves and after assisting another client. RN1 confirmed that staff are to perform hand hygiene when moving from one client to another and immediately after removing gloves.<br><br>Review of facility policy titled "Policy and Procedures for Infection Control & [and] Prevention of Communicable Diseases" stated, ". . . Handwashing is required after gloves are removed and before providing care to another client. . ." | W0341 | | |
| W0369 | DRUG ADMINISTRATION<br><br>CFR(s): 483.460(k)(2)<br><br>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure that medications for one of four clients (Client (C)2) in the home were administered without error. As a result of this deficient practice, C2 was placed at risk of decreased efficacy and/or absorption of her diabetes medication. | W0369 | | |

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| W0369 | Continued from page 7<br>Findings include:<br><br>On 03/18/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The clients (C) of the home include four individuals with intellectual disabilities, one profound, and three mild.<br><br>On 03/18/25 at 06:53 PM, SA began observations of Staff (S)1 preparing and administering medications. At 07:00 PM, observed S1 administer Metformin (a diabetes medication) 500 milligrams, two tablets, to Client (C)2. Review of the Medication Administration Record noted that the Metformin had orders to be given "with breakfast and dinner." Earlier observations documented by the SA confirmed that C2 had completed dinner at 05:11 PM, almost two hours earlier.<br><br>On 03/19/25 at 06:10 AM, observed S3 administer Metformin 500 milligrams, two tablets, to C2. Earlier observations documented by the SA confirmed that C2 had completed breakfast at 05:12 AM (despite the instructions for it to be given with breakfast).<br><br>Interview with Registered Nurse (RN)1 on 03/20/25 at 10:08 AM confirmed that staff have been instructed repeatedly by herself and pharmacy staff the importance of administering medications on time and per the medication orders. | W0369 | | |
| W0382 | DRUG STORAGE AND RECORDKEEPING<br><br>CFR(s): 483.460(l)(2)<br><br>The facility must keep all drugs and biologicals locked except when being prepared for administration.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>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 three of four Clients (C) in the home.<br><br>Findings include: | W0382 | | |

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| W0382 | Continued from page 8<br>On 03/18/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The clients of the home include four individuals with intellectual disabilities, one profound, and three mild. The three clients with mild intellectual disabilities are all independently ambulatory and freely move about their home as they please.<br><br>Observations made in the home on 03/19/25 from 05:17 AM to 06:45 AM noted the medication closet consistently left unlocked as Staff (S)3 and S5 conducted morning care and tasks, including medication administration.<br><br>On 03/19/25 at 05:38 AM, an interview was done with S3 at the medication administration table. S3 confirmed that the medication closet should always be kept locked and locked it. At 06:00 AM S3 unlocked the medication closet to prepare medications and left it unlocked.<br><br>At 06:15 AM, S3 departed from the Home, leaving S5 alone with the four clients, with the medication closet remaining unlocked. At 06:45 AM, the medication closet was still observed unlocked.<br><br>Review of the facility's policy and procedure, Storage and Handling of Drugs, last revised 11/29/22, revealed the following:<br><br>"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."<br><br>Interview with Registered Nurse (RN)1 on 03/20/25 at 10:08 AM confirmed that staff are taught to lock the medication closet between clients. | W0382 | | |
| W0394 | LABORATORY SERVICES<br><br>CFR(s): 483.460(n)(2)<br><br>If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter.<br><br>This STANDARD is NOT MET as evidenced by: | W0394 | | |

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| W0394 | Continued from page 9<br><br>Based on record review and interview, the facility did not have an active CLIA (Clinical Laboratory Improvement Amendments) waiver for performing CLIA-waived tests such as blood glucose testing.<br><br>Finding includes:<br><br>On 03/18/25 at 03:18 PM while making observations of staff providing care at the client's residence, Staff (S)1 was seen placing a sharps container in the medication cabinet. When asked what the sharps container was for, S1 said they use it to dispose of the lancet used to test Client (C)2's blood glucose in the morning.<br><br>On 03/19/25 at 02:26 PM, a concurrent interview and record review was conducted with the Program Manager (PM) in her office. Review of the facility's CLIA certificate of waiver stated an expiration date of 12/08/21. PM acknowledged that the certificate is expired, and they recently replaced the laboratory director noted in the old certificate.<br><br>On 03/19/25 at 03:21 PM, a telephone interview with the CLIA Surveyor for the Department of Health, Office of Health Care Assurance revealed that ORI - House 3-A does not have an active CLIA certificate of waiver. CLIA Surveyor added that if the facility replaces their laboratory director, she needs to be notified within 30 days of the change so it can be reflected in the CLIA certificate of waiver. | W0394 | | |
| W0454 | INFECTION CONTROL<br><br>CFR(s): 483.470(l)(1)<br><br>The facility must provide a sanitary environment to avoid sources and transmission of infections.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observations, interview, and record review, the facility failed to provide and ensure a sanitary environment as evidenced by opened and unlabeled food in the dry foods pantry, food stored on the floor of the dry foods pantry, a dirty bathroom floor and poorly cleaned shower chair in one of two bathrooms, and a buildup of dust on various surfaces. As a result of this deficient practice, the clients were exposed to potential sources of illness and/or infection. | W0454 | | |

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| W0454 | Continued from page 10<br><br>Findings include:<br><br>On 03/18/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The clients (C) of the home include four individuals with intellectual disabilities, one profound, and three mild. The three clients with mild intellectual disabilities are all independently ambulatory and roam around the house at-will.<br><br>1) On 03/18/25 at 02:53 PM, observations were made in one of two bathrooms in the home. Observed deep brown markings on the floor in front of the sink, and a shower chair in the shower with heavily discolored, large, deep brown markings on the seat and seat back in a pattern of where one's body would rest while using the shower chair.<br><br>At 03:35 PM, an interview was done with Staff (S)4 in the bathroom. S4 stated that bathrooms in the home are cleaned on a daily basis by the night staff. When observing the shower chair, S4 agreed that the shower chair looked like it needed to be thoroughly cleaned. S4 also confirmed that the deep brown markings on the bathroom floor was dirt and should have been cleaned.<br><br>Review of the facility's undated policy and procedure, Repair and Maintenance, revealed the following:<br><br>"The residential and day training program staff must keep the facilities in a safe and sanitary condition."<br><br>Review of the facility's undated policy and procedure, Housekeeping Schedule, revealed the following:<br><br>"A plan shall be made for routine, periodic cleaning of the entire building and premises."<br><br>2) On 03/18/25 at 03:05 PM, observations were made of the dry goods pantry/closet with S4. Observed opened crackers in an unlabeled plastic container, dry cereal in a separate unlabeled plastic container, and a large plastic container of Cheese | W0454 | | |

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| W0454 | Continued from page 11<br>Balls that were not labeled with an open date, all on shelves. Also observed a large plastic container on the floor of the pantry that contained a small amount of dry white rice. A concurrent interview with S4 was done where S4 confirmed that opened food should be dated when opened and food should not be kept on the floor.<br><br>Review of the facility's undated policy and procedure, Storage and Handling of Food and Nutritional Service, revealed the following:<br><br>"Foods shall be stored in covered containers and labeled."<br><br>"Store food supply at least 2 inches above the floor."<br><br>3) On 03/18/25 at 02:56 PM, Observations were made around the living room, kitchen and laundry areas. Observed a buildup of dust on the top of the refrigerator, on top of the television cabinet, on the wall mounted hand sanitizer dispenser and cabinets in the laundry room. S4 acknowledged that there was dust building up on the above mentioned surfaces. | W0454 | | |
| E0015 | Subsistence Needs for Staff and Patients<br><br>CFR(s): 483.475(b)(1)<br><br>§403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1),<br>§485.542(b)(1), §485.625(b)(1)<br><br>[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:<br><br>(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: | E0015 | | |

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| E0015 | Continued from page 12<br>(i) Food, water, medical and pharmaceutical supplies<br><br>(ii) Alternate sources of energy to maintain the following:<br><br>(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br><br>(B) Emergency lighting.<br><br>(C) Fire detection, extinguishing, and alarm systems.<br><br>(D) Sewage and waste disposal.<br><br>*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.<br><br>(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:<br><br>(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:<br><br>(A) Food, water, medical, and pharmaceutical supplies.<br><br>(B) Alternate sources of energy to maintain the following:<br><br>(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.<br><br>(2) Emergency lighting.<br><br>(3) Fire detection, extinguishing, and alarm systems.<br><br>(C) Sewage and waste disposal.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility did not implement policies and procedures for subsistence needs of all residents, staff, and visitors who remain in the clients' residence during an emergency. This deficient practice would place all residents, staff, and volunteers who remained at the residence during an emergency at risk for unmet basic needs.<br><br>Findings include: | E0015 | | |

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| E0015 | Continued from page 13<br><br>On 03/18/25 at 03:01 PM, observed Staff (S)4 unlock and open a storage cabinet next to Client (C)4's room. The cabinet contained food items like canned foods, cup noodles, crackers, and bottles of water. Asked S4 if the items in the cabinet were the regular food supplies for the clients or were for emergencies. S4 stated they were for both regular supplies and for emergencies. Noted that there were sixteen 20-ounce bottles of water in the cabinet. When asked if the water bottles were part of the emergency supplies, S4 stated they were.<br><br>On 03/19/25 at 02:08 PM, an interview with the Program Manager (PM) was conducted in the conference room. Asked PM if the emergency food and water supply for the clients and staff were kept in the residence. PM said they were. Asked PM how much food and water should be kept at the residence. PM said, "There should be enough for five days per policy." Shared with PM observed amount of water kept at the residence, sixteen 20-ounce bottles. PM acknowledged there is not enough water for four clients and two staff.<br><br>Review of document titled "Residential Disaster Preparedness Plan" that was in the facility's emergency preparedness binder stated, "1. Water Supply: A good rule of thumb is to store one (1) gallon of drinking water per person per day. Plan for at least 5 days. For example, a family of six should store 30 gallons of drinking water. . ." | E0015 | | |
| E0039 | EP Testing Requirements<br><br>CFR(s): 483.475(d)(2)<br><br>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).<br><br>*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:<br><br>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: | E0039 | | |

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| E0039 | Continued from page 14<br><br>(i) Participate in a full-scale exercise that is community-based every 2 years; or<br><br>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or<br><br>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.<br><br>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.<br><br>*[For Hospices at 418.113(d):]<br><br>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:<br><br>(i) Participate in a full-scale exercise that is community based every 2 years; or<br><br>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or<br><br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the | E0039 | | |

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| E0039 | Continued from page 15<br>emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:<br><br>(i) Participate in an annual full-scale exercise that is community-based; or<br><br>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or<br><br>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a | E0039 | | |

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| E0039 | Continued from page 16<br>narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.<br><br>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]<br><br>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:<br><br>(i) Participate in an annual full-scale exercise that is community-based; or<br><br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br><br>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.<br><br>*[For PACE at §460.84(d):] | E0039 | | |

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| E0039 | Continued from page 17<br><br>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:<br><br>(i) Participate in an annual full-scale exercise that is community-based; or<br><br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or<br><br>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.<br><br>*[For LTC Facilities at §483.73(d):]<br><br>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:<br><br>(i) Participate in an annual full-scale exercise that is community-based; or | E0039 | | |

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| E0039 | Continued from page 18<br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br><br>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.<br><br>*[For ICF/IIDs at §483.475(d)]:<br><br>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:<br><br>(i) Participate in an annual full-scale exercise that is community-based; or<br><br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.<br><br>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an additional annual exercise that may | E0039 | | |

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| E0039 | Continued from page 19<br>include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.<br><br>*[For HHAs at §484.102]<br><br>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at<br><br>least annually. The HHA must do the following:<br><br>(i) Participate in a full-scale exercise that is community-based; or<br><br>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.<br><br>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.<br><br>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:<br><br>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or<br><br>(B) A mock disaster drill; or<br><br>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a | E0039 | | |

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| E0039 | Continued from page 20<br>narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.<br><br>*[For OPOs at §486.360]<br><br>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:<br><br>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.<br><br>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.<br><br>*[ RNCHIs at §403.748]:<br><br>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:<br><br>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br><br>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.<br><br>This STANDARD is NOT MET as evidenced by: | E0039 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G040 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/20/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **OPPORTUNITIES AND RESOURCES, INC (HOUSE 3-A)** | **64-1510 KAMEHAMEHA HIGHWAY , WAHIAWA, Hawaii, 96786** |

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| E0039 | Continued from page 21<br>Based on interview and record review the facility failed to provide documentation of exercises to test the emergency plan at least twice per year. The facility failed to document a facility-based functional exercise, mock disaster drill, or a tabletop exercise. This deficiency could affect all clients, staff, and visitors during an emergency due to the staff's lack of knowledge and ability to perform policies and procedures.<br><br>Findings Include:<br><br>On 03/19/25 at 02:08 PM, a concurrent interview and review of the facility's emergency preparedness binder was conducted with the Program Manager (PM) in the conference room. Asked PM if the facility performed two activities required to test emergency preparedness, one of which should be facility-based functional test, mock disaster drill or a tabletop exercise. PM showed documentation of the facility's participation during the RIMPAC (Rim of the Pacific) exercise in July 2024 and an attendance sign-in sheet for a tabletop exercise dated 02/06/25. When asked if there was documentation of what was discussed during the tabletop exercise, PM said, "We only have the sign-in sheet." No tabletop discussion form was found in the emergency preparedness binder. | E0039 | | |
| W0462 | FOOD AND NUTRITION SERVICES<br><br>CFR(s): 483.480(a)(3)<br><br>If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and record review, the facility failed to ensure that in the absence of a full-time qualified dietitian, there was a designated director of food services to coordinate with the dietician consultant to assure the nutritional adequacy of meals and snacks. This deficient practice places the clients in the home at risk of not having their nutritional needs met.<br><br>Findings include:<br><br>On 03/18/25, the State Agency (SA) entered the home to conduct an annual recertification survey. | W0462 | | |

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| W0462 | Continued from page 22<br>The clients (C) of the home include four individuals with intellectual disabilities, one profound, and three mild.<br><br>Review of the posted breakfast menu in the home, which had been prepared by Staff (S)1, for the month of March revealed several days in the month with the following:<br><br>Cereal with milk, coffee with milk, some type of fruit, and water.<br><br>At least one day with the following:<br><br>Toasted bread with jam and jelly, coffee with milk, some type of fruit, and water.<br><br>Many/most days with prepackaged processed foods such as hot dogs, pepperoni pizza, hot pockets, corn dogs and waffles.<br><br>The menu reflected breakfasts low in protein and high in processed foods.<br><br>On 03/20/25 at 09:46 AM, an interview was done with the Program Manager (PM) in her office. PM confirmed that the facility Registered Dietician (RD) works as a consultant only, responding to as needed referrals and conducting the annual Nutritional Assessments. PM also confirmed that the facility did not have a designated Food Service Director (FSD). PM was not aware of the requirement for an FSD in the absence of a full-time RD. | W0462 | | |
| W0477 | MENUS<br><br>CFR(s): 483.480(c)(1)(i)<br><br>Menus must be prepared in advance.<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, the facility failed to ensure that meal planning was prepared in advance. Although able to provide evidence of menus prepared in advance, the meal planning did not extend to ensuring the facility had the materials necessary to prepare the planned meals as written. As a result of this deficient | W0477 | | |

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| W0477 | Continued from page 23<br>practice, six of nine meals served during the survey period had "substitutions" made. Some substitutions were an entirely different meal. This deficient practice places the clients of the facility at risk of not having their nutritional needs met.<br><br>Findings include:<br><br>On 03/18/25, the State Agency (SA) entered the home to conduct an annual recertification survey. The clients (C) of the home include four individuals with intellectual disabilities, one profound, and three mild.<br><br>On 03/18/25 at 04:30 PM, an interview was done with Client (C)4 in the home. When asked what she had for breakfast that morning, C4 stated they had hot dogs, French toast, and coffee. A review of the Breakfast Menu for March 2025 posted in the home revealed that the planned menu was fully cooked sausage links, coffee with milk, grapes, and water.<br><br>Observations in the home on 03/19/25 at 05:15 AM noted the breakfast served was hot pockets, banana, and coffee, while the posted menu reflected that kiwi had been planned to be served. Interview with Staff (S)3 at 05:23 AM confirmed that she had to "substitute" bananas because they did not have any kiwis.<br><br>Review of the March 2025 Lunch Menu revealed the following planned for 03/18/25: Roast Turkey with gravy, mashed potatoes, toss salad with dressing, and Jello. Handwritten in was the following: "Substitute Kalua [pork] cabbage, Pears, carrots ..."<br><br>Planned for 03/19/25 was the following: Creole spaghetti, garlic bread, toss salad with dressing, and applesauce. Handwritten in was the following: "Substitute Beef stew macaroni, rice, salad, Jello ..."<br><br>Review of the March 2025 Dinner Menu noted that on 03/18/25 and 03/19/25 the main dishes planned had also been changed and handwritten in to something different. Pork Katsu had been replaced with Teri Meatballs on 03/18/25 and Baked Fish was replaced with Turkey with Gravy on 03/19/25. | W0477 | | |