STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ORI - HOUS... B. WING	(X3) DATE SURVEY COMPLETED 04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOUSE 1-A)	**64-1510 KAMEHAMEHA HIGHWAY , WAHIAWA, Hawaii, 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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code survey was conducted by the Hawai'i Department of Health, Office of Health Care Assurance (OHCA), on 04/24/2026 at the facility (CCN: 12G030). Based on survey findings, the facility was determined to be out of compliance with the Life Safety Code requirements for an existing small Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) under 42 CFR 483.470(j)(1)(i). The facility, constructed in 1984, is a 1-story single-family residential home of Type V (000) wood-frame construction and is fully sprinklered throughout . At the time of the survey, the small ICF/IID had 5 certified beds and a census of 4.	K0000		
KA353 Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked. _____ b) Who provided system test. _____ c) Water system supply source. _____ Provide in REMARKS information on coverage for	KA353		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G030	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - ORI - HOUS...** B. WING	(X3) DATE SURVEY COMPLETED **04/24/2026**

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KA353 Bldg. 01	Continued from page 1 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review, observation, and interview, the facility failed to ensure that the automatic sprinkler system was inspected, tested, and maintained in accordance with NFPA 25 (2011), Sections 5.2.1.1.2, 5.3.2.1, and 14.2.1, as required by NFPA 101 (2012), Section 9.7.5. Failure to maintain sprinkler heads free of foreign materials and loading, replace or test sprinkler system gauges every 5 years, and conduct the required 5-year internal inspection of sprinkler system piping could result in delayed sprinkler activation, inaccurate pressure readings, and undetected pipe obstructions during a fire, potentially placing all 4 residents, staff, and visitors at risk. On 04/24/2026 at 11:25 AM, during document review, the facility was unable to produce documentation demonstrating that the required 5-year internal pipe inspection of the sprinkler system had been performed. Additionally, the facility was unable to provide documentation showing that the sprinkler system gauges had been tested or replaced within the past 5 years. On 04/24/2026 at 1:05 PM, during the facility tour, a sprinkler head loaded with dust was observed in Room 4. On 04/24/2026 at 2:00 PM, during the facility tour, a sprinkler gauge was observed bearing a marked date of 2016, verifying that it was beyond the required 5-year replacement or testing interval. These findings were acknowledged by the Facility Administrator and Maintenance Supervisor at the time of discovery and confirmed during the exit interview.	KA353		
KA712 Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to - a. Ensure that all personnel on all shifts are trained	KA712		

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KA712 Bldg. 01	Continued from page 2 to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must - a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure that fire drills were conducted at least quarterly for each shift of personnel and under varied conditions, in accordance with NFPA 101 (2012), Sections 4.7.4 and 33.7.3, and 42 CFR 483.470(i). Failure to conduct and vary fire drills across all shifts prevents staff from being adequately trained and prepared to perform assigned tasks during a fire emergency, potentially placing all 4 residents, staff, and visitors at risk. On 04/24/2026 at 11:40 AM, during record review, the facility’s fire drill logs revealed that drills did not occur at varying times and were missed on required shifts. Specifically, in the second quarter of 2025, April through June, there were no fire drills performed during the day shift. In the third quarter of 2025, July through September, all three fire drills were conducted during the night shift, with none performed during the day or evening shifts. These findings were acknowledged by the Facility Administrator and Maintenance Supervisor at the time of discovery and confirmed during the exit interview.	KA712		

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the Hawai'i Department of Health, Office of Health Care Assurance (OHCA), on 04/24/2026 at the facility (CCN: 12G030). Based on survey findings, the facility was determined to be out of compliance with the Emergency Preparedness requirements for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) under 42 CFR 483.475.	E0000		
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E0006		

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E0006	Continued from page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure its emergency plan was based on and included a documented facility-based and community-based risk assessment utilizing an all-hazards approach, in accordance with 42 CFR 483.475(a)(1). Failure to conduct and document a comprehensive risk assessment prevents the facility from effectively identifying and preparing for hazards specific to its location and resident population, potentially placing all 4 residents, staff, and visitors at risk during a disaster or emergency. On 04/24/2026 at 12:00 PM, during document review, the facility was unable to produce a documented all-hazards risk assessment. While the	E0006		

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E0006	Continued from page 2 facility had general policies and procedures addressing potential emergencies, the facility was unable to provide a risk assessment procedure or documentation demonstrating how facility-based and community-based hazards were evaluated and used to develop the emergency plan. This finding was acknowledged by the Facility Administrator and Maintenance Supervisor at the time of discovery and confirmed during the exit interview.	E0006		
E0018	Procedures for Tracking of Staff and Patients CFR(s): 483.475(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [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 at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.	E0018		

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E0018	Continued from page 3 (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track the location of on-duty staff during and after an emergency, in accordance with 42 CFR 483.475(b)(2). Failure to maintain a staff tracking system prevents the facility from ensuring that all personnel are accounted for during a disaster or evacuation, potentially placing all 4 residents, staff, and visitors at risk. On 04/24/2026 at 12:20 PM, during document review of the facility's emergency preparedness plan, the facility was able to produce tracking logs for residents but was unable to provide a policy,	E0018		

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E0018	Continued from page 4 procedure, or other means by which on-duty staff would be tracked during and after an emergency. This finding was acknowledged by the Facility Administrator and Maintenance Supervisor at the time of discovery and confirmed during the exit interview.	E0018		