

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G030		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/20/2024	
NAME OF PROVIDER OR SUPPLIER OPPORTUNITIES AND RESOURCES, INC (HOUSE 1-A)				STREET ADDRESS, CITY, STATE, ZIP CODE 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
E0000	Initial Comments			E0000			
	No Information						
W0000	INITIAL COMMENTS A desk review follow-up was conducted by the Office of Health Care Assurance on 05/20/24. All deficiencies cited as a result of the recertification survey conducted on 02/23/24 were found to be corrected. The facility is in substantial compliance with program requirements at 42 CFR §483, Conditions of Participation (COP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).			W0000			

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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