STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPPORTUNITIES AND RESOURCES, INC (HOUSE 1-B)	**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 A recertification survey was conducted by the Office of Health Care Assurance from 07/23/2025 to 07/25/2025. The facility was found to be in substantial compliance with the requirements at §483.475, Emergency Preparedness.	E0000		
W0000	INITIAL COMMENTS A focused fundamental recertification survey was conducted by the Office of Health Care Assurance on 07/23/2025 to 07/25/2025. The facility was found not to be in substantial compliance with the requirement at 42 CFR §440.150, Subpart I, Condition of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Survey Dates: 07/23/2025 to 07/25/2025 Facility Census: 4 Clients Sample Size: 2 Clients	W0000		
W0340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) 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 training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is NOT MET as evidenced by: Based on interviews and record review, the facility failed to implement and train staff on how and when to perform control testing for glucometers to ensure the glucometers/test strips are accurate. As a result of this deficient practice, there is the risk for more than minimal harm to residents who require blood glucose checks.	W0340		

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: 12G031	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/25/2025

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W0340	Continued from page 1 Findings include: On 07/24/25 at 06:00 AM, after medication pass was completed, inquired with House Staff (HS)1 regarding how staff perform control test for the glucometers/test strips for two Clients (C) who reside in the house, C2 and C3. HS1 was did not know how to perform a control test for the glucometer/test strips and did not receive training on how to perform a control test. HS1 confirmed the house staff do not test the glucometers at the house and is unaware if the Facility Nurse (FN)1 comes to the house to test the glucometer. On 07/25/25 at 10:29 AM, conducted a telephone interview with FN1. Inquired if control testing are performed for the glucometers and test strips for C2 and C3's equipment. FN1 confirmed staff have not been trained on how to perform control testing for the glucometers/test strips and no control testing is currently being conducted. FN1 confirmed performing control testing on the glucometer/test strips would be best practice and should be done.	W0340		