

Hawaii Dept. of Health, Office of Health Care Assurance

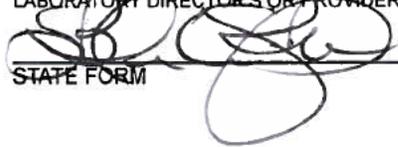
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HI02LTC5065	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2015
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NAME OF PROVIDER OR SUPPLIER CLARENCE TC CHING VILLAS AT ST FRANCIS	STREET ADDRESS, CITY, STATE, ZIP CODE 2230 LILIHA STREET HON, HI 96817
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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
4 000	11-94.1 Initial Comments An initial State Licensure survey was conducted on May 18, 2015. The facility meets all the requirements for State Licensure.	4 000		

RECEIVED
 2015 JUL 24 P 3:01
 STATE OF HAWAII
 DEPT. OF HEALTH
 DIVISION OF LICENSING

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
W. H. H. A.

(X6) DATE
5/20/2015