Hawaii Dept. of Health, Office of Health Care Assuranc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12G037	A. BUILDING: _____ B. WING _____	04/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ARC OF MAUI - MANA OLA	450 KANALOA AVENUE KAHULUI, HI 96732

(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
9 000	INITIAL COMMENTS A licensure survey was conducted from April 13, 2016 to April 15, 2016 by the State Agency. The client census was 5 (five). The facility met all requirements pursuant to Tile 11, Chapter 99 for Small Intermediate Care Facilities for the Mentally Retarded.	9 000		

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

Valerie Sky

TITLE: Program Director

(X6) DATE: 5/6/16

[redacted]