

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125040	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2020
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF HILO	STREET ADDRESS, CITY, STATE, ZIP CODE 944 WEST KAWAILANI STREET HILO, HI 96720
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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	<p>Initial Comments</p> <p>A focused state re-licensure survey was conducted by the Office of Health Care Assurance on 05/04/2020. At the time of entrance, the facility's census included 220 residents.</p> <p>The facility was found to be in substantial compliance with Chapter 11-94.1, "Nursing Facilities" of the Hawaii Administrative Rules, at Sections 11-94.1-53 Infection control, 11-94.1-29 Resident abuse, neglect, and misappropriation of resident property, 11-94.1-36 Admission, transfer, and discharge, 11-94.1-39 Nursing services, and 11-94.1-58 Emergency preparedness.</p>	4 000		

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/08/20
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