

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125063</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/17/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>15 CRAIGSIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>15 CRAIGSIDE PLACE HONOLULU, HI 96817</b>
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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 COVID-19 Focused Infection Control and Relicensing Survey was conducted by the Office of Health Care Assurance (OHCA) on July 17, 2020. The facility was found to be in compliance with Title 11, Chapter 94.1 rules and regulations.</p> <p>Total residents: 39</p>	4 000		

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE <b>07/24/20</b>
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