Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125063	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
15 CRAIGSIDE	**15 CRAIGSIDE PLACE HONOLULU, HI 96817**

(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	Initial Comments A licensure survey was conducted by the Office of Health Care Assurance on 05/25/22 to license additional beds. The facility is requesting licensure of four additional beds (two beds in room 201 and two beds in room 202) for an increase of 41 to 45 beds. The facility was found to be in compliance with the Hawaii Administrative Rules, Title 11, Chapter 94.1, Nursing Facilities, Subchapter 7 Physical Facility Standards at §11.94.2-65, Construction Requirements.	4 000		

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/08/22