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 _____	08/25/2023

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	11-94.2-0 Initial Comments On 08/25/23 a relicensure survey was conducted by the Office of Health Care Assurance (OHCA). The Department of Health, OHCA has accepted the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a full relicensing inspection as authorized by chapter 11-94.2-6(e) Hawaii Administrative Rules (HAR). Refer to the federal Medicare recertification survey report to see citations and plans of correction. The census at the time of entrance was 45 residents.	4 000		

Office of Health Care Assurance

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

Electronically Signed