

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2023
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PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER HALE NANI REHABILITATION AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1677 PENSACOLA STREET HONOLULU, HI 96822
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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>11-94.2-0 Initial Comments</p> <p>The Department of Health, Office of Health Care Assurance conducted a recertification survey on 07/14/23. The facility was found not be in compliance with §42 CFR 483, Subpart B. The Office of Health Care Assurance will accept the federal Medicare recertification survey results of this facility for state relicensing purposes and has exempted this facility from a relicensing inspection as authorized by Hawaii Administrative Rules (Chapter 11-94.2) at §11-94.2-6(e). Refer to the federal Medicare recertification survey report to review the statement of deficiencies and the facility's plan of correction.</p>	4 000		

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