PRINTED: 10/03/2023 FORM APPROVED

Hawaii Dept. of Health, Office of Health Care Assurance
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  91-575 FARRINGTON HIGHWAY  KAPOLEI, HI 96707  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG  TAG  THE Department of Health, Office of Health Care Assurance has accepted the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a 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.   | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |     |  |
|---|---|--|--|---|---|-------------------------------|-----|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ### STARRINGTON HIGHWAY ### KAPOLEI, HI 96707    (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)   TAG   THE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  ### A 000   11-94.2-0 Initial Comments   |   |  |  | A. BOILDING                                 |   |                               |     |  |
| SUMMARY STATEMENT OF DEFICIENCIES   DEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   The Department of Health, Office of Health Care Assurance has accepted the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a 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   SUMMARY STATEMENT OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE   CROSS-REFERENCED TO THE APPROPRIATE DATE      A 000 |   |  | 125051   | B. WING                                     |   | 05/05/2023                    |     |  |
| KAPOLEI, HI 96707  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 000 11-94.2-0 Initial Comments  The Department of Health, Office of Health Care Assurance has accepted the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a 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   |   |  |  |   |   |                               |     |  |
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| The Department of Health, Office of Health Care Assurance has accepted the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a 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   | PREFIX  | (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | PREFIX                                      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |                               | ETE |  |
| Assurance has accepted the federal Medicare recertification of this facility for state relicensing purposes and has exempted this facility from a 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   | 4 000   | 00 11-94.2-0 Initial Comments  |  | 4 000                                       |   |                               |     |  |
|   |   | The Department of H Assurance has accept recertification of this for purposes and has extrelicensing inspection 11-94.2-6(e) Hawaii A Refer to the federal M survey report to see of | ealth, Office of Health Care bed the federal Medicare facility for state relicensing empted this facility from a n as authorized by chapter Administrative Rules (HAR). Medicare recertification |   |   |                               |     |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/26/23