

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125055</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/10/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HI'OLANI CARE CENTER AT KAHALA NUI</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>4389 MALIA STREET HONOLULU, HI 96821</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>11-94.2-0 Initial Comments</p> <p>The Department of Health, Office of Health Care Assurance conducted a recertification survey on August 10, 2023. 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 of this facility for state relicensing purposes and has exempted this facility from a relicensing inspection as authorized by Chapter 11-94.2, Hawaii Administrative Rules, §11-94.2-6(e). Refer to the federal Medicare recertification survey report to review the statement of deficiencies and the facility's plans of correction.</p>	4 000		

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  09/20/23
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