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
	12G001	A. BUILDING: _____ B. WING _____	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KULA HOSPITAL	100 KEOKEA PLACE KULA, HI 96790

(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
9 000	INITIAL COMMENTS A re-licensure survey was conducted by the State Agency from 10/22/24 through 10/25/24. The facility was found to be in compliance with Title 11, Chapter 99, Intermediate Care Facilities for Individuals with Intellectual Disabilities.	9 000		

Office of Health Care Assurance

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