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 |
|---|---|---|---|
| | 125023 | A. BUILDING: _____ B. WING _____ | 10/18/2024 |



| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LANAI COMMUNITY HOSPITAL** | **628 7TH STREET LANAI CITY, HI 96763** |

| (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<br><br>The Department of Health, Office of Health Care Assurance (OHCA) has accepted the Federal Medicare recertification of the 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, if any, and plans of correction.<br><br>Survey dates: 10/14/24 to 10/18/24<br><br>Survey Census: 10<br><br>Sample size: 8 | 4 000 | | |

Office of Health Care Assurance

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

Electronically Signed