

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/01/2023
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NAME OF PROVIDER OR SUPPLIER SAMUEL MAHELONA MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 4800 KAWAIHAU ROAD KAPAA, HI 96746
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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 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.</p> <p>Survey Census: 49 Sample Size: 17</p>	4 000		

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 01/05/24
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