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
	125013	A. BUILDING: ________ B. WING ________	08/29/2024

PENDING ACKNOWLEDGEMENT

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAUNALANI NURSING AND REHABILITATION CENTE	5113 MAUNALANI CIRCLE HONOLULU, HI 96816

(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 The Department of Health, Office of Health Care Assurance, conducted a recertification survey on August 26 to 29, 2024. The facility was found not 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 plan of correction. Census at the time of entrance: 88 Sample size 18	4 000		

Office of Health Care Assurance

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

Electronically Signed