

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/07/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>HILO BENIOFF MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1190 WAIANUENUE AVENUE HILO, HI 96720</b>		
(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 has accepted the Federal Medicare Recertification of this facility, conducted on 01/07/25, 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.	4 000		

Office of Health Care Assurance  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE