

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 12G027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/26/2025
--	---	---	---

NAME OF PROVIDER OR SUPPLIER THE ARC IN HAWAII - KAIMUKI B	STREET ADDRESS, CITY, STATE, ZIP CODE 811 19TH AVENUE 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
{9 000}	<p>INITIAL COMMENTS</p> <p>A follow up desk review was conducted by the office of Healthcare assurance on June 26, 2025. The facility is in substantial compliance with program requirements.</p>	{9 000}		

Office of Health Care Assurance LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------