Office of Health Care Assurance

State Licensing Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: **Hi'olani Assisted Living Center at Kahala Nui**	**CHAPTER 90**
Address: **4389 Malia Street, Honolulu, Hawaii 96821**	**Inspection Date: February 12, 2026 Annual**

THIS PAGE MUST BE SUBMITTED WITH YOUR PLAN OF CORRECTION. IF IT IS NOT, YOUR PLAN OF CORRECTION WILL BE RETURNED TO YOU, UNREVIEWED.

YOUR PLAN OF CORRECTION MUST BE SUBMITTED WITHIN TEN (10) WORKING DAYS. IF IT IS NOT RECEIVED WITHIN TEN (10) DAYS, YOUR STATEMENT OF DEFICIENCIES WILL BE POSTED ONLINE, WITHOUT YOUR RESPONSE.

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
☒	§11-90-8 Range of services. (a)(2) Service plan. A service plan shall be developed and followed for each resident consistent with the resident's unique physical, psychological, and social needs, along with recognition of that resident's capabilities and preferences. The plan shall include a written description of what services will be provided, who will provide the services, when the services will be provided, how often services will be provided, and the expected outcome. Each resident shall actively participate in the development of the service plan to the extent possible; **FINDINGS** Resident #1 - Service plan was not updated to reflect the current order, "Obtain weight weekly for weight monitoring," as ordered by the physician on 11/13/25. Service plan (12/2/25) stated that "resident's weight will be checked monthly by staff to monitor significant changes." *Submit the revised service plan with your plan of correction.*	**PART 1** **DID YOU CORRECT THE DEFICIENCY?** **USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY**	

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Licensee's/Administrator's Signature: _____

Print Name: _____

Date: _____