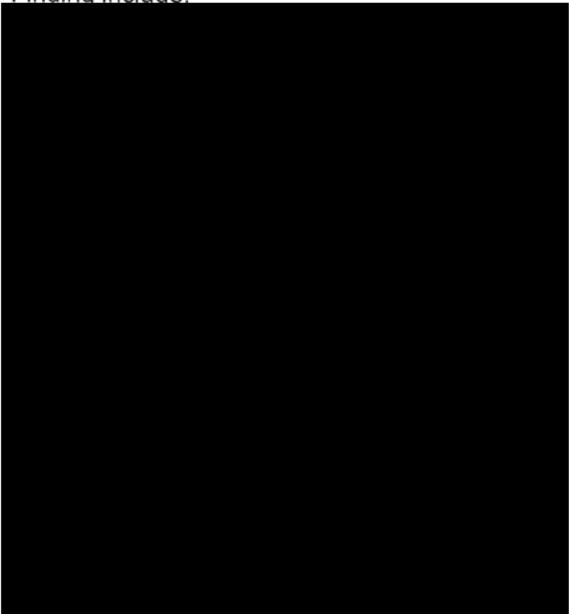


Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>2/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>KFH - MALAMA 'OHANA NURSING AND REHA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3288 MOANALUA ROAD HONOLULU, HI 96819</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) COMPLETION DATE
4 000	11-94. 1 Initial Comments  A state relicensure survey was conducted at the facility from 2/9-2/11/16. There were 10 residents at the facility upon entrance.	4 000		
4 106	11-94. 1-22(h) Medical record system  (h) All information contained in the resident's record, including any information contained in an automated data bank, shall be considered confidential and adhere to requirements as set forth by the Health Insurance Portability and Accountability Act of 1996.  This Statute is not met as evidenced by: The facility failed to protect the residents clinical records during a medication pass observation.  Finding include: 	4 106	<p>STATE OF HAWAII DOH-OHCA MEDICARE 2016 MAR -3 A 11:44 RECEIVED</p> <p>Complete 15 weekly random audits to ensure mobile computer cart is closed when staff are away from the computer. Findings of the audits will be submitted to the Accreditation Committee monthly.</p> <p>Provide training to staff at our annual Skills Fair regarding confidentiality for all resident's medical records and Resident's Rights.</p>	<p>February 21, 2016</p> <p>April 18, 2016</p>

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

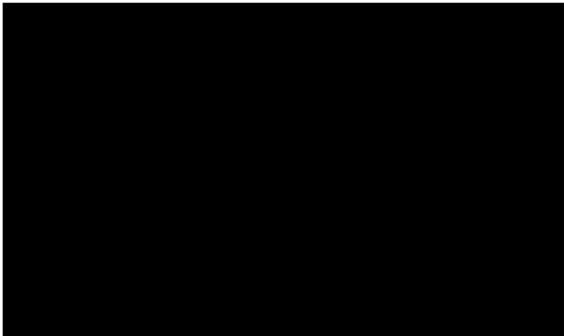
TITLE

(X6) DATE

*Dale H. Steakley* | Dale H. Steakley, MBA, BSN, RN-BC, CUSRN, LNHA Licensed Administrator | 02/29/2016

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>2/11/2016</b>
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4 106	Continued From page 1 	4 106	
4 228	<p>11-94. 1-57(f) Life safety</p> <p>(f) Fire drills shall be conducted at least quarterly, for each shift, under varied conditions. At least twelve drills shall be held every year and reports filed in the facility and available for review by the department.</p> <p>This Statute is not met as evidenced by: Based on surveyor review of the facility's fire drill records on 2/10/16 at approximately 1:00PM, the facility failed to conduct fire drills in accordance with Section; 18.7.1.2.</p> <p>1. There was a pattern in the times that fire drills were conducted on the 3<sup>rd</sup> Shift (Night Shift 23:15P- 07:15A) in the 1st, 2nd &amp; 3rd Quarters of Calendar Year 2015. Fire drills were conducted on: (1st Quarter); 3/12/15 @ 2320, (2nd quarter); 6/30/15 @ 2340 &amp; (3rd quarter; 8/2/15 @ 2320.</p> <p>2. The facility failed to provide documentation that a fire drill was conducted on the 3rd Shift in the 4rd Quarter (October, November &amp; December) of Calendar Year 2015.</p>	4 228	<p>Will perform fire drills at random times throughout various shifts quarterly.</p> <p>February 24, 2016</p> <p>Will simulate fire drills on the night shift at random times, not just at start of shift, quarterly. Finding will be reported to the Accreditation Committee.</p> <p>February 24, 2016</p>