Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125057	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kulana Malama	91-1360 Karayan Street Ewa Beach, HI 96706

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 125057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2025
NAME OF PROVIDER OR SUPPLIER Kulana Malama		STREET ADDRESS, CITY, STATE, ZIP CODE 91-1360 Karayan Street Ewa Beach, HI 96706	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to assure one of seven residents (R) 25, sampled for Respiratory Care, had documentation of two unplanned decannulations of her tracheostomy tube. The deficient practice does not reflect R25's health status when there was a change in her condition which required prompt staff intervention to maintain her airway. This deficient practice could affect all residents in the facility who have a tracheostomy tube and experience an unplanned decannulation that staff are not documenting a change with the resident in the resident's Electronic Health Record (EHR). Findings Include:On 09/25/25 lead surveyor requested and received a list of adverse events that occurred within the last six months from the Administrator. Review of the incident log provided revealed R25 had two unplanned decannulations on 06/18/25. Requested copies of incident reports and root cause analysis for decannulation that occurred with R25 on 06/18/25 from the administrator which she was able to provide on 09/25/25 at 05:05 PM. Review of the incident reports found the following: Facility incident report on 06/18/25 at 1430 (02:30 PM) stated R25 had been provided care by Certified Nurse Aide (CNA) 17 and CNA32 who witnessed R25's decannulation. CNA17 and CNA32 documented in the incident report After we changed her diaper, we were about to reposition her and she started laughing, she titted (sic.) her head back and her trach came out. Registered Nurse (RN) 17 documented on the same incident report R25 decannulated after her diaper was changed. She was laughing and her trach came out. Per CNA she called for help. RT (respiratory therapist) reinserted the trach w/o difficulty, no issues. SpO2 100% HR (heart rate) 80's, trach ties [NAME], not loose prior and during incident. Resident hyperextended neck and trach came out. Review of R25's progress notes in her EHR did not reveal a progress note written by a nurse or RT regarding this unplanned decannulation. Facility incident report for second decannulation with R25 stated the incident occurred on 06/18/25 at 22:45 (10:45 PM). CNA 29 and CNA15 documented the decannulation was witnessed and Changing brief leading to hyperextension of neck meanwhile holding trach tubing beeping of vent leading to decrease in respiration, looking/assessing what happened/why vent is beeping, call RN, Assess trach tube dressing and saw trach tubing out of trachea and trach tie was tied/ not loose. RN24 documented what was reported Saw trach out while performing care, beeping of vent was occurring, assessing and saw trach dressing, lifted trach dressing and saw trach tube of out trachea. Review of R25's progress notes did not reveal a progress note written by a nurse regarding this unplanned decannulation. On 09/26/2025 at 10:24 AM interviewed Respiratory Services Supervisor (RSS) in the conference room. Inquired of RSS about R25's two incidents of unplanned decannulation with her tracheostomy tube on 06/18/25. RSS reported R25 was refitted for a custom size trach which is longer and helps to prevent decannulation from occurring. RSS stated R25's trach was short and contributed to the decannulation when R25 hyperextended her neck. On 09/26/2025 at 10:58 AM interviewed Respiratory Therapist (RT) 16 in the conference room. Inquired about the incident with R25 that occurred on 06/18/25 when she had a decannulation of her tracheostomy tube. RT16 confirmed he was working this day and stated he believes he was assigned to R25. RT16 confirmed he helped when the decannulation occurred and he responded when staff yelled for help, and he put the trach back in. RT16 stated She (R25) was not in distress. Inquired if R25's O2 saturations decreased and RT16 stated he could not remember if she desated and stated there was no color change. She tolerates a quick decannulation okay. Inquired if he charted this incident in R25's EHR and he stated he did not believe it is expected of him to chart in the EHR this change that occurred with R25. On 09/26/2025 at 11:44 AM interviewed the Director of Nursing (DON) in the conference room. Inquired who would document an incident such as a decannulation of a resident's tracheostomy tube and he stated the nurse. DON confirmed the nurse who responded to the incident would document in the residents EHR about the incident. Requested a copy of the facility's documentation policy which the DON provided. Review of the facility policy Nursing Documentation in the Medical Record states Purpose: To provide a legal record of the nursing care that has been administered; to keep an accurate record of the resident's condition and course of stay; and to provide guidelines for documenting in the medical record. Policy: Nursing staff are required to document care provided to the resident in the medical record and to use the documentation as a means of communication and coordination of care with other healthcare providers. This includes Progress Notes, .