

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Facility's Name: Winmax Senior Care, L.L.C.	CHAPTER 100.1
Address: 3808 Harding Avenue, Honolulu, Hawaii 96816	Inspection Date: April 28, 2023 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.

STATE OF HAWAII
DEPARTMENT OF HEALTH
JUN -5 PM 2:19

	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (e)(3) The substitute care giver who provides coverage for a period less than four hours shall:</p> <p>Be currently certified in first aid;</p> <p><u>FINDINGS</u> Substitute Care Giver (SCG) #1 – No current first aid certification as it was completed online only.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Substitute Care Giver is no longer an employee of MSC. Unable to provide a correction for this deficiency.</p>	<p>JV</p> <p>23 JUN -5 12:19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-9 <u>Personnel, staffing and family requirements.</u> (f)(1) The substitute care giver who provides coverage for a period greater than four hours in addition to the requirements specified in subsection (e) shall:</p> <p>Be currently certified in cardiopulmonary resuscitation;</p> <p><u>FINDINGS</u> SCG #1 – No current cardiopulmonary resuscitation certification as it was completed online only.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Substitute Care Giver is no longer an employee of MSC. Unable to provide a correction for this deficiency.</p>	<p>JV</p> <p>23 JUN -5 PM 2:19</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-13 <u>Nutrition.</u> (l) Special diets shall be provided for residents only as ordered by their physician or APRN. Only those Type I ARCHs licensed to provide special diets may admit residents requiring such diets.</p> <p><u>FINDINGS</u> Resident #2 – No documented evidence the low salt diet ordered on 4/20/2023, was clarified with the physician or APRN.</p>	<p>PART 1</p> <p><u>DID YOU CORRECT THE DEFICIENCY?</u></p> <p>USE THIS SPACE TO TELL US HOW YOU CORRECTED THE DEFICIENCY</p> <p>Diet order clarified with physician on 4/28/23. Clarification order "Regular Diet, Chopped Texture."</p>	<p>4/28/23 JV</p> <p>23 JUN -5 P12:19 STATE OF CONNECTICUT STATE LIAISON</p>

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	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p>FINDINGS Resident #1 – Physician’s order dated 12/16/2022, states, “Compression stockings thigh high: Apply to lower extremities, on every morning and remove before bed.” During annual inspection on 4/28/2023, the medication administration record (MAR) had been initialed indicating the stockings were put on; however, the resident was not wearing them.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>23 JUN -5 PM 2:19</p>

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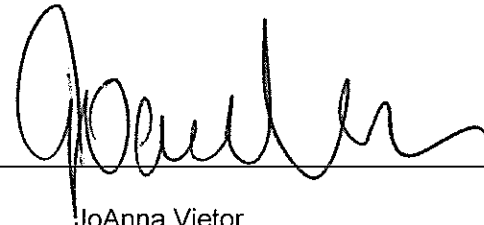
	RULES (CRITERIA)	PLAN OF CORRECTION	Completion Date
<input checked="" type="checkbox"/>	<p>§11-100.1-17 <u>Records and reports.</u> (b)(4) During residence, records shall include:</p> <p>Entries describing treatments and services rendered;</p> <p>FINDINGS Resident #1 – No documented evidence that the fluid restriction 2L/day ordered on 4/6/2023 was provided as ordered.</p>	<p>PART 1</p> <p>Correcting the deficiency after-the-fact is not practical/appropriate. For this deficiency, only a future plan is required.</p>	<p>23 JUN -5 PM 11:19</p> <p>STATE OF MA MASS SMA00000000</p>

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STATE OF CONNECTICUT
DEPARTMENT OF
SOCIETY SERVICES

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Licensee's/Administrator's Signature: _____



Print Name: JoAnna Vietor

Date: _____

5/30/23

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