



STATE OF WASHINGTON  
 DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
 AGING AND LONG-TERM SUPPORT ADMINISTRATION  
 PO Box 98907, Lakewood, WA 98496

RECEIVED  
 APR 19 2016  
 DSHS RCS Region 3

Statement of Deficiencies	License #: 531102	Completion Date
Plan of Correction	GAPP AFH	March 17, 2016
Page 1 of 3	Licensee: GROUP ACTION FOR	

You are required to be in compliance with all of the licensing laws and regulations at all times to maintain your adult family home license.

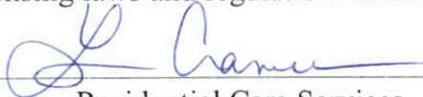
The department has completed data collection for the unannounced on-site full inspection of: 3/4/2016 and 3/7/2016

GAPP AFH  
 8725 STATE RD 302 NW  
 GIG HARBOR, WA 98329

The department staff that inspected the adult family home:  
 Gary Fuentebella, Licensor

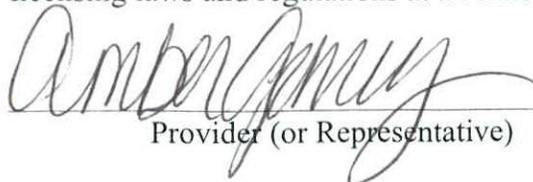
From:  
 DSHS, Aging and Long-Term Support Administration  
 Residential Care Services, Region 3, Unit A  
 PO Box 98907  
 Lakewood, WA 98496  
 (253)983-3826

As a result of the on-site full inspection the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

  
 Residential Care Services

3/24/16  
 Date

I understand that to maintain an adult family home license I must be in compliance with all the licensing laws and regulations at all times.

  
 Provider (or Representative)

3/31/16  
 Date

3/19  
 5/17

**WAC 388-76-10225 Reporting requirement.**

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(c) The resident's health care provider;

**This requirement was not met as evidenced by:**

Based on observation, interview and record review the home failed to notify the health care provider (primary physician) in a timely manner for 1 of 5 residents (Resident #1) when he was sent and admitted to the hospital because of a significant change in condition. This failure prevented the health care provider of being informed of Resident #1's current medical status.

**Findings include:**

Resident #1 was admitted to the home with diagnoses to include [REDACTED] and [REDACTED]. Resident #1's assessment dated 11/17/15 revealed he had memory problems, made poor decisions; was dependent with transferring, bed mobility, personal hygiene and bathing. Resident #1 also needed assistance with eating, toileting and dressing.

On 3/4/16 interview with the Entity Representative (ER) revealed Resident #1 was sent and admitted to the hospital on [REDACTED] 16 after Caregiver E, Caregiver F and Caregiver I found Resident #1 with blood on his bed. The ER said Resident #1's department case manager, guardian and nurse delegator were notified of his hospitalization and admission. The ER added Resident #1 was to be possibly readmitted back to the adult family home the next day [REDACTED] 16).

On 3/4/16 review of an incomplete Incident Report (IR) dated [REDACTED] 16 revealed Caregiver E noted Resident #1 had blood running out of the right side of his mouth at 7:00 a.m. Both left and right arms were observed swollen and 911 was called. Resident #1 was sent to the hospital. The IR report documented that the ER, RM, and Resident #1's guardian were notified of the incident on [REDACTED] 16.

On 3/4/16 the ER said she will complete the IR and fax a copy to the Licensor for review.

On 3/7/16 Resident #1 was observed sitting on a [REDACTED] in the dining room and was being spoon-fed by Caregiver L. Resident #1 appeared relaxed and comfortable was not interviewable.

On 3/7/16 review of Resident #1's hospital records revealed he stayed in the hospital from [REDACTED] 16 and was discharged back to the AFH on [REDACTED] 16. Resident #1's hospital diagnoses included [REDACTED]

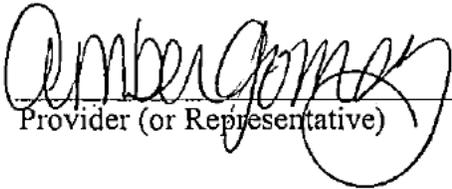
On 3/10/16 the Licensor received a copy of Resident #1's complete IR dated [REDACTED] 16 documenting the ER, RM, Resident #1's guardian, department case manager, nurse delegator and AFH board president were notified of the incident on [REDACTED] 16. The IR report documented Resident #1's primary physician was notified of the incident and hospitalization on 3/7/16 [REDACTED] when they called to set-up a follow-up appointment.

On 3/14/16 during a telephone interview, the ER said there was a miscommunication between caregivers that occurred on [redacted] 16 that resulted in Resident #1's primary physician not being immediately notified. The ER added the RM was in-charge of ensuring Resident #1's primary physician was notified of the incident but the RM's daughter was also in the hospital on [redacted] 16 which resulted in the miscommunication problems.

This is a repeated and uncorrected Washington Administrative Code (WAC) violation previously cited on 2/11/15.

**Attestation Statement**

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, GAPP AFH is or will be in compliance with this law and / or regulation on (Date) 3-19-16 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.

  
Provider (or Representative)

3-31-16  
Date

March 31, 2016

RE: WAC 388-76-10225 Reporting requirement:

(2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify:

(c) The resident's health care provider

When it was discovered that our call to the physician on 3/7 was delayed, I immediately created a new Emergency Check Off List form for staff to use as a guide to insure all parties are notified. [REDACTED] is now on hospice so his enclosed Emergency Check Off List form is a bit different since we call hospice first and proceed as directed by them. Gary, our inspector, has already been given a copy of the Emergency Check Off List form.

At the same time we streamlined the process of calling all interested parties so the staff on duty complete all of the calling at the time of the emergency, including calling the Resident Manager, DeAnna Brock and me. I am responsible for contacting the state persons listed on the form.

Staff was trained on the Emergency Call Check Lists for [REDACTED] and all other residents when they returned to work on their next shifts. After each staff was trained, they each signed and dated to confirm they have been trained. I have enclosed the sign off sheet for our Emergency Call Check List.

Our next scheduled staff meeting is on April 12, 2016 and we will retrain all staff on WAC 388-76-10225 Reporting requirement on that date. We hold monthly staff meetings. Reporting requirements, including our Emergency Check Off List will be addressed at every staff meeting for the next year.

Amber Gomez

Group Home Administrator

Entity Representative

GAPP License #531102