STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20311 52nd Ave W, Suite 100, Lynnwood, WA 98036

HEART TO HEART LOVING CARE INC
HEART TO HEART LOVING CARE
21329 9TH AVE SE
BOTHELL, WA 98021

RE: HEART TO HEART LOVING CARE # 752027

Dear Provider:

This document references Compliance Determination 27329 (08/07/2023), which included complaint number(s) 90094.

The Department completed a complaint investigation of your Adult Family Home on 08/07/2023 and found that your home does not meet the Adult Family Home Licensing requirements.

The department staff who did the inspection and provided consultation:

Tekeste Demissie, Complaint Investigator

A licensor may consult with a provider when a violation of the Washington Administrative Code (WAC) or Revised Code of Washington (RCW) is found, but it is not cited in the Statement of Deficiencies. Violations may not be cited when it is a first-time violation of statute or rule with minimal or no harm to residents. A consult does not require a follow-up visit.

Consultation:

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:

(a) The resident's family;

(b) The resident's representative, if one exists;

The Adult Family Home (AFH) failed to inform Resident 3's Family/Representative that Resident 3 had a bruise of unknown origin. Staff A (Provider) completed an in-service training to 3 of 3 caregivers regarding required documentation and reporting of incidents.

You Must:
- Begin the process of correcting the deficiency or deficiencies immediately; and
- Complete correction as soon as possible.

You Are Not:
- Required to submit a plan-of-correction for the deficiency or deficiencies found.

The Department May:
- Inspect the home to determine if you have corrected all deficiencies.

You May:
- Ask for a informal dispute resolution meeting, according to the attached 'Informal Dispute Resolution' instructions; and
- Ask questions and provide written information to help clarify or dispute the deficiencies.
- Contact me for clarification of the deficiency or deficiencies found.

If You Have Any Questions:
- Please contact me at (206)914-5042.

Sincerely,

Renee' Bourque

Renee Bourque, Field Manager
Region 2, Unit I
Residential Care Services

INFORMAL DISPUTE RESOLUTION [RCW 70.128]

You May:
Request an Informal Dispute Resolution (IDR) meeting within 10 working days after the date you receive this letter. You **must** use an **'IDR Request Form'** for **each** citation or enforcement you plan to dispute. You can find this form and directions on the IDR Adult Family Home web page at: https://www.dshs.wa.gov/altsa/idr

Provider Process for Choosing a Panel or Traditional IDR:

You may only choose a **Panel IDR** if you are disputing **three or fewer** citations or enforcement actions. You may choose a **Traditional IDR** regardless of the number of citations or enforcement actions you intend to dispute. If you choose a **Panel IDR**, all documents supporting your dispute must be submitted within **20 working days** after the date you receive this letter. For **Panel IDRs** the program will not consider any documents submitted after the **20 working day deadline**. For **Traditional IDRs** you should submit documents supporting your dispute at least **seven** days prior to the date of the IDR meeting.

Send your request and supporting documents to the address below or email to rcsidr@dshs.wa.gov:

Adult Family Home IDR Program
Residential Care Services
PO Box 45600
Olympia, WA 98504-5600

Residential Care Services
Investigation Summary Report

Provider/Facility: HEART TO HEART LOVING CARE
Provider Type: Adult Family Home
License/Cert.#: 752027
Intake ID: 90094
Compliance Determination #: 27329
Region/Unit #: RCS Region 2 / Unit I
Investigator: Tekeste Demissie
Investigation Date(s): 07/28/2023 through 08/07/2023
Complainant Contact Date(s):

Allegation(s):

1. The Adult Family Home (AFH) was not giving the Named Resident (NR) food the family brought resulting in significant weight loss.
2. The Adult Family Home (AFH) failed to inform the NR's representative that NR had bruise.

Investigation Methods:

Sample:	Total residents: 7 Resident sample size: 3 Closed records sample size:
Observations:	Adult Family Home Environment, Resident Appearance, Resident to Staff Interaction, Direct Resident Care.
Interviews:	Residents, Staff, Provider, Resident Representatives.
Record Reviews:	Resident Records, Incident Logs, AFH Policies and Procedures, Third Party Provider Notes

Investigation Summary:

1. Observation showed the NR was in the room siting in wheelchair and pulling drawers. The other residents of the AFH were well-groomed and in clean clothing. There was fresh food in the fridge and in cabinets. Observation showed the AFH had various meats and vegetables available as well as packaged foods. During an interview, the NR's representative reported that the AFH might not give the NR the food family brings. In an interview, the NR stated they have been getting enough food, they do not have any problem with eating, and they have been eating 3 meals a day. In an interview, Resident 6 and 7 stated they have no concern with the meals provided and they don't think they lost any weight. In an interview, Staff B and C (caregivers) denied not giving the NR the food family bring. The Staff B and C stated they were serving three meals, snacks, and the food the family brought based on the NR preferences. Record review showed no significant weight loss between admission weight and recent weight at doctor visit.

2. Observation showed NR was in the room siting in wheelchair and pulling drawers. The NR had a faded bruise on their forehead that was healing. In an interview, the NR

stated they did not know how the bruises happened. In interview, the AFH Staff B and C stated the NR had a tendency of leaning forward and rearranging NR drawers in their room. Record review of the NR's assessment and Negotiated Care Plan (NCP) showed NR bruises easily due to medical diagnosis. Record review showed NR bruise was documented on incident log without information of who was informed. See Consult Dated 08/08/2023.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A