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 License # 752027

Dear Provider:

This letter addresses Compliance Determination(s) 38376 (Completion Date 03/15/2024) and 32487 (Completion Date 01/16/2024).

The Department completed a follow-up inspection of your Adult Family Home on 03/15/2024 and found that you have corrected the violations listed in the Complaint report dated 01/16/2024. Your home is back in compliance as of 01/19/2024 with the cited requirements of the Washington Administrative Code or the Revised Code of Washington or both.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-76-10225-2-c, WAC 388-76-10225-2-f, WAC 388-76-10400-2, WAC 388-76-10400-3-a, WAC 388-76-10400-3-b, WAC 388-76-10400-4

The Department staff who did the on-site verification:
Nylay Quist, AFH Complaint Investigator

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

Residential Care Services
Investigation Summary Report

Provider/Facility: HEART TO HEART LOVING CARE
Provider Type: Adult Family Home
License/Cert.#: 752027
Intake ID: 106012
Compliance Determination #: 32487
Region/Unit #: RCS Region 2 / Unit I
Investigator: Nylay Quist
Investigation Date(s): 11/14/2023 through 01/16/2024
Complainant Contact Date(s): 01/17/2024

Allegation(s):

1. The Named Resident (NR) has injury from being physically and verbally abused by the Adult Family Home (AFH) staff

Investigation Methods:

Sample:	Total residents: 4 Resident sample size: 2 Closed records sample size: 0
Observations:	Exterior/Interior General Tour The NR Resident/Staff interaction Safety system Resident's room
Interviews:	AV AP Sample resident staff Resident's rep/Family Case Manager
Record Reviews:	Resident record Incident/Injury log Abuse& Neglect policy MAR Hospital record Background check

Investigation Summary:

1.Observation shows, the NR is not at the AFH, and their room is empty. In an interview, the Reporter/family stated, the NR was admitted in the hospital on [redacted]/2023 with multiple bruises and is diagnose with [redacted]. The reporter stated the NR will not go back to the AFH because the NR needs more care than the AFH can offer. In an interview the NR and sample residents stated they feel safe living in the AFH, and the caregiver have not yelled at them or hurt them. In an interview the AFH staff stated they treat all residents with respect and will report any abuse or neglect to the state reporting hotline. The AFH staff stated the NR had multiple falls with bruising in October 2023 and they only report the incidents to the NR's representative. They did not report the incidents to the NR's doctor or Case Manager. See Statement of Deficiency (SOD) dated 01/17/2024.

Conclusion / Action:

- [X] Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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Statement of Deficiencies	License #: 752027	Compliance Determination # 32487
Plan of Correction	HEART TO HEART LOVING CARE	Completion Date
Page 1 of 5	Licensee: HEART TO HEART LOVING CARE INC	01/16/2024

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Adult Family Home license.

The department completed data collection for an unannounced on-site complaint investigation on 11/14/2023 and 11/14/2023 of:

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

This document references the following complaint number(s): 106012, 103876

The following sample was selected for review during the unannounced on-site visit: 2 of 4 current residents and 0 former residents.

The department staff that investigated the Adult Family Home:

Nylay Quist, AFH Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit I
20311 52nd Ave W, Suite 100
Lynnwood, WA 98036

As a result of the on-site visit(s), 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.

Renee' Bourque
Residential Care Services

01/18/2024
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) Date 1/19/2024

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;

(f) The resident's case manager if the resident is a department client.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to notify the Health Care Provider (HCP) and Case Manager (CM) for 1 of 4 residents (Resident 1) when Resident 1 had multiple falls with bruising and a potential injury. This failure resulted in Resident 1 sustaining an undiagnosed [redacted] and unmet care needs.

Findings included ...

Record review of the AFH Medical Emergency Policy dated 06/03/2022 showed, the AFH staff should call 911 and provider all information needed by the 911 dispatcher. The AFH staff should contact the resident's representative, Primary doctor, and Case Worker, and call the DSHS hotline to report incident.

Record review of Resident 1's AFH record showed Resident 1 admitted to the AFH on [redacted]/2022 with diagnoses that included [redacted], and [redacted].

In an interview, on 1/14/2023 at12:35PM, Staff B (Caregiver) stated that they were aware that Resident 1 had a fall on 10/07/2023 and 10/22/2023. Staff B stated they reported both incidents to the Resident 1 representative and Staff A (AFH Provider) only. Staff B stated that they had not reported the incident to anyone else. Staff B stated they had not reported it to anyone else because Staff A already knew about the falls.

During an interview on 11/16/2023 at 3:45PM, Staff A stated that they reported the incidents to Resident1's representative only and had not reported to anyone else. Stated A stated that they had not called 911, reported Resident 1's fall to the Case Manager, or to Resident 1's Doctor because they had not thought Resident 1 had any injury. Staff A stated that Resident 1's condition had not changed, and that Resident 1's representative had not instructed them to do anything else about the fall incidents.

Review of the AFH incident log showed, Resident 1 had a fall on 10/07/2023. The incident log indicated, the AFH staff found Resident 1 under their bed with a big bruise on their right arm. The AFH documented that they reported to Resident 1's representative only. Resident 1 had another fall on 10/22/2023. The incident log indicated the AFH staff found Resident 1 next to their bed with bruises on their hip, knee, and hand. The AFH documented that they reported to Resident 1's representative only.

Review of an email from Resident 1's Case Manager on 12/16/2023 showed they never received any notification from any AFH staff when Resident 1 had a fall on 10/07/2023 and 10/22/2023.

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, HEART TO HEART LOVING CARE is or will be in compliance with this law and / or regulation on (Date) 1/19/2024 .

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) — Date: 1/19/2024

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(2) The necessary care and services to help the resident reach the highest level of physical, mental, and psychosocial well-being consistent with resident choice, current functional status and potential for improvement or decline.

(3) The care and services in a manner and in an environment that:

(a) Actively supports, maintains or improves each resident's quality of life;

(b) Actively supports the safety of each resident; and

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on interview and record review, the Adult Family Home (AFH) failed to have a system in place to ensure 1 of 4 residents (Resident 1) received necessary care and services after multiple falls. This failure resulted in Resident 1 sustaining a fracture, and unmet care needs.

Findings included ...

Record review of Resident 1's AFH record showed Resident 1 admitted to the AFH on [redacted]/2022 with diagnoses that included [redacted].

Review of Resident 1's hospital record, dated [redacted]/2023, showed, Resident 1 had bruising in their low back and buttock area. Resident 1 was diagnosed with a new [redacted]. Review showed the hospital report stated, "this appears from recent trauma within the last week it would appear".

During an interview, on 11/14/2023 at 7:01AM, Collateral Contact 1 (CC1) (anonymous), stated that Resident 1 was sent to a local hospital on [redacted]/2023. CC1 stated that the hospital Doctor reported that Resident 1 had multiple bruises on their body and a neck injury.

During an interview, on 11/16/2023 at 3:11PM Resident 1 stated that they think they had falls in the AFH. Resident 1 stated that they do not remember what happened or when it happened. Resident 1 stated that they might have had an injury from the fall, but they cannot recall specific injury. Resident 1 stated that they do not remember anyone helping them up.

During an interview, on 11/16/2023 at 3:45PM, Staff A (AFH Provider) stated that they were aware that Resident 1 had a fall on 10/07/2023 with bruising on their right arm. Staff stated that the AFH documented that they reported to Resident 1's representative only. Staff A stated they placed a bed alarm on Resident 1's mattress after the 10/07/2023 fall incident. Staff A stated that Resident 1 had another fall on 10/22/2023 with bruises on right hip, right knee, and right hand. Staff A stated they did not call 911 or report the fall incidents to Resident 1's Case Manager or the doctor because they had not thought Resident 1 had any injury. Staff A stated that there were no change in Resident 1's condition.

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, HEART TO HEART LOVING CARE is or will be in compliance with this law and / or regulation on (Date) 11/19/2024.

In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

Provider (or Representative) [signature] Date 1/19/2024

PLAN OF CORRECTIONS

Heart to Heart Loving Care INC

License# 752027

Date: 01/19/2024

WAC 388-76-10400 Care and services.

Correction plan:

Date: 01/19/2024

We have corrected this matter and will provide care and services based on the assessment and negotiated care plan. Working together with the POA and PCP and all other parties involved in the overall care and well being of the resident. (Home health, case manager, nurse delegator, hospice, etc...). See attached sheet that will be put in every residents care folder and signed by the provider.

WAC 388-76-10225 Reporting requirement.

Correction Plan:

Date: 01/19/2024

We have created an incident report form and an incident report sheet, please see attached forms. We will put them all in an incident folder along with the adult family incident log, Abuse and neglect policy and emergency policy. We have instructed all staff on the reporting requirements for incidents such as falls, injury, accident, behavioral and medication errors, etc...

Providers name: Osceola Beuca

Providers signature: _____ Date 1/19/2024