



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Avenue, Suite#220, Vancouver, WA 98684

September 1, 2016

ADRIANA N SUCIU
HEAVEN HOME CARE
14104 NE 30TH COURT
VANCOUVER, WA 98686

RE: HEAVEN HOME CARE License #750314

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on August 31, 2016 for the deficiency or deficiencies cited in the report/s dated July 19, 2016 and found no deficiencies.

The Department staff who did the inspection:
Shawn Swanstrom, Licensor

If you have any questions please, contact me at (360) 397-9549.

Sincerely,

Karyl Ramsey, Field Manager
Region 3, Unit E
Residential Care Services



**Residential Care Services
Investigation Summary Report**

Provider/Facility: HEAVEN HOME CARE (687794) **Intake ID(s):** 3231559
License/Cert. #: AF750314
Investigator: Swanstrom, Shawn **Region/Unit:** RCS Region 3/Unit E **Investigation Date(s):** 06/21/2016 through 07/19/2016
Complainant Contact Date(s): 06/20/2016, 07/22/2016

Allegations:

- # 1 - The Provider was upset and yelled at the Named Resident.
- # 2 - The NR was unable to eat meals at the dining room table.
- # 3 - The Provider is not managing the NR medications.

Investigation Methods:

- Sample:** 2 + one discharged Resident
- Observations:** General environment, resident rooms, general appearance of residents, staff-to-resident interactions, and medications.
- Interviews:** Named and sampled residents, the provider, staff, family members, and others not associated with the home.
- Record Reviews:** Resident records.

Allegation Summary:

- # 1 - The NR stated the Provider did yell. The NR moved from the home. Other sampled family members stated the Provider and the Resident Manager raised their voice when talking.
- # 2 - The NR stated [redacted] stopped eating meals in the dining room after [redacted] became ill and never went back.
- # 3 - The NR stated [redacted] was getting her medications.

Unalleged Violation(s): **Yes** **No**

Conclusion / Action: **Failed Provider Practice Identified / Citation(s) Written** **Failed Provider Practice Not Identified / No Citation Written**



**Residential Care Services
Investigation Summary Report**

WAC 388-76-10510 (2) which states the adult family home must ensure that each resident is treated with courtesy. See Statement of Deficiency dated 7/19/2019.



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AUG 03 2016

DSHS/ADSA/RCS

Statement of Deficiencies	License #: 750314	Completion Date
Plan of Correction	HEAVEN HOME CARE	July 19, 2016
Page 1 of 4	Licensee: ADRIANA SUCIU	

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 complaint investigation of: 6/21/2016 and 7/19/2016

HEAVEN HOME CARE
 14104 NE 30TH COURT
 VANCOUVER, WA 98686

This document references the following complaint number: 3231559

The department staff that inspected and investigated the adult family home:
 Shawn Swanstrom, RN, BSN, Licensor

From:

DSHS, Aging and Long-Term Support Administration
 Residential Care Services, Region 3, Unit E
 800 NE 136th Avenue, Suite#220
 Vancouver, WA 98684
 (360)397-9549

As a result of the on-site complaint investigation 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.

C. Burinsky for Hazel Bessy
 Residential Care Services

07/26/2016
 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.

Adriana Suciu
 Provider (or Representative)

7/30/16
 Date

WAC 388-76-10510 Resident rights Basic rights. The adult family home must ensure that each resident:

(2) Is treated with courtesy;

This requirement was not met as evidenced by:

Based on interviews and record review the adult family home failed to ensure two of two current residents (Resident # 1 and # 2) and one discharged Resident (Resident # 3) were treated with courtesy. This deficient practice resulted in two residents moving from the home (Resident # 1 and # 3). This deficient practice diminished the resident's quality of life.

Findings include:

An onsite visit was made to the home on 6/21/2016. Resident # 1 stated [REDACTED] wanted to talk with the investigator, though [REDACTED] was worried about retaliation. Resident # 1 stated [REDACTED] was moving from the home. [REDACTED] stated another agency had been in the home to talk with [REDACTED] and the Provider and Resident Manager were very upset with [REDACTED]. Resident # 1 stated [REDACTED] was scared to talk and asked that [REDACTED] be interviewed after [REDACTED] moved from the home.

Resident # 2 was resting in bed, was alert, though conversation was [REDACTED]

Resident # 1's family member was interviewed on 6/22/2016 and stated that the Provider and Resident Manager had always been nice to [REDACTED] until the other agency had come out to the home. The family member stated the Provider had told her Resident # 1 had turned them in and caused her (the Provider) to do so much paper work. The Provider stated if Resident # 1 was not happy why didn't [REDACTED] (Resident # 1) move instead of turning them in. The Provider told the family member that Resident # 1 complains all the time.

Resident # 1's family member stated the Resident Manager stuck his finger out at [REDACTED] (in [REDACTED] face) and stated the reason why the Provider is so stress out was because of Resident # 1.

Resident # 1's family member stated Resident # 1 was very social and liked to talk with others. Resident # 1 was told [REDACTED] talked too much at the dining room table. When Resident # 1 became ill in December 2015 [REDACTED] started eating all meals in [REDACTED] room.

Resident # 1 was interviewed in [REDACTED] new place of living on 7/11/2016. Resident # 1 stated [REDACTED] was happy to be out of the home. Resident # 1 stated [REDACTED] was told if she could not be quite when at the dining room table [REDACTED] could eat all [REDACTED] meals in [REDACTED] room. Resident # 1 stated [REDACTED] got sick in December, and ate in [REDACTED] room. Resident # 1 stated [REDACTED] was never again invited back to the dining room.

Resident # 1 stated for a short time [REDACTED] shared a "Jack and Jill" bathroom (one bathroom - two different doors) with Resident # 3. [REDACTED] stated [REDACTED] was told not to talk with Resident # 3. After a short time Resident # 3 moved from the home.

Resident # 1 stated both the Provider and the Resident Manager would raise their voices at [REDACTED]. If [REDACTED] asked questions about what was going on around the home, [REDACTED] was told it was none of [REDACTED] business.

Resident # 1 stated the Provider and Resident Manager made [REDACTED] feel terrible. Resident # 1 stated the physical care was very good at the home and did not feel physically threatened.

Discharged Resident # 3's family was contacted on 7/15/2016. They stated Resident # 3 was encourage not to talk to Resident # 1. Resident # 3's family member stated Resident # 3 had a diagnoses of [REDACTED]. The family member stated the Resident Manager's tone was not friendly when he talked with Resident # 3. The Resident Manager would attempt to explain house rules to Resident # 3 and this would only [REDACTED] and [REDACTED] more. Prior to the first 30 days the Provider told the family member Resident # 3 could not stay at the home if [REDACTED] continued to be [REDACTED]. Resident # 3's family member stated this was their first time in an adult family home, did not understand/know the rules and thought the provider could just evict Resident # 3 without assisting the family in finding another place to live.

Resident # 3's family member stated they found a new home and Resident # 3 moved from the adult family home.

Resident # 2's Legal Guardian was interviewed on 7/13/2016. She stated Resident # 2 was transferred to the hospital and decision was made to have Resident # 2 be transferred to a higher level of care. When she went to the home to retrieve some of Resident # 2 personal belongings she stated she was treated terribly by the Provider. She stated the Provider's voice was raised and was agitated related to Resident # 2 not be returning to the home.

A follow up visit was made to the adult family home on 7/19/2016 to review reported issues with the Provider and Resident Manager (spouse of the Provider).

They stated Resident # 1 was becoming more and more confused and started to complain about how [REDACTED] was treated at the home. The Provider stated she had issued an eviction notice (dated 6/8/2016) and after the eviction notice Resident # 1 started to complain more and more.

The Provider and Resident Manager stated it was Resident # 1 who complained that Discharged Resident # 3 talked too much. The Provider stated it was Resident # 1 who did not want to go to the dining room for meals and talk with Resident # 3.

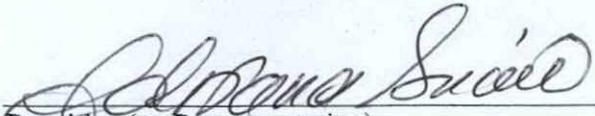
The Provider and Resident Manager stated Resident # 3 was confused and they tried to meet [REDACTED] needs, though were unable.

The Provider stated she is aware her voice is loud and she talks fast, though she does not feel as she is yelling at the residents.

The Resident Manager stated he talks with his hands and did not point his finger in Resident # 1's family members face.

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, HEAVEN HOME CARE is or will be in compliance with this law and / or regulation on (Date) 7/30/16 . In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.


Provider (or Representative)

7/30/2016
Date