STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
3906-172nd St NE, Suite #100, Arlington, WA 98223

CRINA BAEZ
SYLVAN CREST
7518 HEATHER WAY
EVERETT, WA 98203

RE: SYLVAN CREST License # 466302

Dear Provider:

This letter addresses Compliance Determination(s) 50843 (Completion Date 11/25/2024) and 48493 (Completion Date 11/05/2024).

The Department completed a follow-up inspection of your Adult Family Home on 11/25/2024 and found that you have corrected the violations listed in the Full report dated 11/05/2024. Your home is back in compliance as of 11/15/2024 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 388-76-10650-1, WAC 388-76-10650-2-a, WAC 388-76-10650-2-b, WAC 388-76-10650-2-c, WAC 388-76-10265-1-d

The Department staff who did the off-site verification:

Kimberly Rush, Long Term Care Surveyor
Toni Bolo, Complaint Investigator

If you have any questions, please contact me at (206)348-9350.

Sincerely,

Nicholette Flynn, Field Manager
Region 2, Unit B
Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

3906-172nd St NE, Suite #100, Arlington, WA 98223

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 the unannounced on-site full inspection on 10/08/2024 and 10/08/2024 of:

SYLVAN CREST
7518 HEATHER WAY
EVERETT, WA 98203

The following sample was selected for review during the unannounced on-site visit: 2 of 5 current residents and 0 former residents.

The department staff that inspected the Adult Family Home:

Kimberly Rush, Long Term Care Surveyor
Toni Bolo, Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 2 , Unit B
3906-172nd St NE, Suite #100
Arlington, WA 98223

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.

Residential Care Services _____ 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

WAC 388-76-10650 Medical devices.

(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.

(2) Before a medical device with a known safety risk is used by a resident, the home must:

(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;

(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;

(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and

This requirement was not met as evidenced by:

Based on observation, record review, and interview, the Adult Family Home (AFH) failed to ensure all requirements were met prior to the use of a [redacted] for 1 of 2 sampled residents (Resident 2). This failure placed Resident 2 at risk for misuse or injury from not knowing the risks before using a [redacted].

Findings included…

Observation on 10/08/2024 at 10:13 AM, showed Resident 2's bed was against a wall and had raised [redacted] on both sides of their [redacted].

Record review showed the AFH admitted Resident 2 on [redacted]/2024 with multiple diagnoses including [redacted], and [redacted]. Resident 2's record did not show a [redacted] assessment. Resident 2's negotiated care plan did not show documentation of [redacted] use. Resident 2's record showed an incomplete consent form that was not signed by the resident.

Interview on 10/08/2024 at 3:56 PM, Staff A (Provider) stated that they were not aware Resident 2 did not have an assessment regarding [redacted] use. Staff A stated that they were not aware that Resident 2's [redacted] use was not documented in the negotiated care plan. Staff A stated they were not aware that the informed consent was not signed by the resident.

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, SYLVAN CREST is or will be in compliance with this law and / or regulation on (Date)_____ .

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

_____ _____

Provider (or Representative) Date

WAC 388-76-10265 Tuberculosis Testing Required.

(1) The adult family home must develop and implement a system to ensure the following persons have tuberculosis testing within three days of employment:

(d) Caregiver;

This requirement was not met as evidenced by:

Based on record review and interview, the Adult Family Home (AFH) failed to ensure 2 of 3 staff (Staff B, & C Caregivers) completed Tuberculosis (TB, a bacterial infection that affects the lungs) testing within three days of their hire date. This failure placed residents and staff at risk of being exposed to a communicable disease.

Findings included…

Record review showed the AFH hired Staff B on 07/20/2015. Staff B's employee file, dated 07/20/2015, showed that Staff B had a negative TB skin test on 09/25/2015. Staff B's employee file showed no documentation of a TB test done within three days of hire.

Record review showed the AFH hired Staff C on 07/17/2023. Staff C's employee file, dated 07/17/2023, showed that Staff C had no documentation of a TB test done within three days of hire.

Interview, on 10/09/2024 at 3:56 PM, Staff A (Provider) stated that they were unaware that staff TB testing needed to be completed within three days of hire.

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, SYLVAN CREST is or will be in compliance with this law and / or regulation on (Date)_____ .

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

Provider (or Representative) Date