STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

07/01/2025

CREF3 Oxford Living Sherwood LLC
Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

RE: Sherwood Assisted Living # 2652

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 62023 (Completion Date 07/01/2025) and 59573 (Completion Date 05/12/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/01/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

The Department staff who did the On Site verification:
Phan Pham, Nurse Surveyor

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley

Clinton Fridley, Adult Family Home Nurse Field Manager
Region 3, Unit E

Residential Care Services

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site follow-up on 05/12/2025 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following SOD dated: 05/12/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 71 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Phan Pham, Nurse Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2652	Compliance Determination # 59573
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 2 of 4	Licensee: CREF3 Oxford Living Sherwood LLC	05/12/2025

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.

Cory Cisneros
Residential Care Services

05/21/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

IAdministrator
Administrator (or Representative)

05/23/2025
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to implement the negotiated service agreement when assisting a resident to transfer for 1 of 3 sampled residents (Resident 3) reviewed. This failure placed the residents at risk for sustaining avoidable injuries.

Findings included...

Record review of the "Department of Social And Health Services" document, Completion date 03/18/2025, showed "As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC (Washington Administrative Code) 388-78A-2160] as stated in the cited deficiencies in the enclosed report. I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times." The administrator section showed Staff D, Administrator, signed the document on 04/03/2025. Staff D signed the "Plan/Attestation Statement" for all citations cited that read "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, [the facility] is or will be in compliance with this law and/or regulation on 05/01/2025."

Review of Resident 3's (R3) face sheet, dated 05/12/2025, showed the resident

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 Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) | Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

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Findings included…

Record review of the “Department of Social And Health Services” document, Completion date 03/18/2025, showed “As a result of the on-site visit(s) the department found that you are not in compliance with the licensing laws and regulations [including WAC (Washington Administrative Code) 388-78A-2160] as stated in the cited deficiencies in the enclosed report. I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.” The administrator section showed Staff D, Administrator, signed the document on 04/03/2025. Staff D signed the “Plan/Attestation Statement” for all citations cited that read “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, [the facility] is or will be in compliance with this law and/or regulation on 05/01/2025.”

Review of Resident 3’s (R3) face sheet, dated 05/12/2025, showed the resident

admitted to the facility on [redacted]/2022 with diagnosis including [redacted].

Review of R3's negotiated service plan, dated 05/08/2025, showed R3 was able to communicate effectively and make their needs known. R3 had weakness, was non-weight bearing, and for safety, R3 required two staff members and a mechanical lift to assist with transfers.

On 05/12/2035 at 11:40 AM, R3 was observed in bed and covered with blankets. R3 said she was waiting for staff members to assist her out of bed.

On 05/12/2025 at 11:50 AM, Staff B, Medication Tech, was observed assisting R3 to transfer from the resident's bed to a wheelchair. Staff B used a mechanical lift and transferred R3 without assistance from another staff member.

In an interview on 05/12/2025 at 12:03 PM, Staff A, Caregiver, said she had been trained to have two staff members when using a mechanical lift to assist residents to transfer. Staff A stated R3 had weakness and needed two staff members for assistance to transfer and that information was documented in R3's service agreement.

In an interview on 05/12/2025 at 2:43 PM, Staff B said R3 had weakness, was non-weight bearing and required two staff members for assistance to transfer. Staff B stated information related to R3's care and services were documented in the service agreement. Staff B said she had been updated on R3's transfer assistance and forgot to ask for additional staff member for assistance.

In an interview at 2:55 PM, Staff C, Resident Care Manager, said Staff B and staff members had been trained to have two staff members when using a mechanical lift to assist residents to transfer. Staff C stated the residents' negotiated service agreements had information related to the level of assistance the residents required. Staff C said she verbally informed staff members and alerted them when the service agreement had been updated. Staff C stated staff members were responsible for reviewing and following the service agreement when assisting residents. Staff C said staff members were encouraged to ask when they had questions related to care, services and assistance the residents required.

This was an uncorrected and recurring deficiency previously cited on 03/18/2025 and 01/03/2025.

Statement of Deficiencies	License #: 2652	Compliance Determination # 59573
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 4 of 4	Licensee: CREF3 Oxford Living Sherwood LLC	05/12/2025

Plan/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, Sherwood Assisted Living is or will be in compliance with this law and / or regulation on (Date) 06/20/2025 .

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

Administrator

Administrator (or Representative)

05/23/2025

Date

Plan/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, Sherwood Assisted Living 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.

_____ _____

Administrator (or Representative) Date

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site follow-up on 03/18/2025 of:
Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following SOD dated: 03/18/2025

The following sample was selected for review during the unannounced on-site visit: 4 of 67 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator
Phan Pham, Nurse Surveyor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

Statement of Deficiencies	License #: 2652	Compliance Determination # 56585
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 2 of 5	Licensee: CREF3 Oxford Living Sherwood LLC	03/18/2025

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.

Cory Cisneros
Residential Care Services

03/27/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Administrator

04/03/2025
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members provided care and services in accordance with the residents' negotiated service agreements for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure placed the residents at risk for decreased quality of life and their dignity not maintained.

Findings included...

Resident 1 (R1)

Review of R1's face sheet, dated 03/18/2025, showed the resident admitted to the facility on [redacted]2023 with diagnosis including [redacted].

Review of R1's negotiated service plan, dated 01/18/2025, showed R1 was able to communicate effectively and make their needs known. R1 required staff assistance with her activities of daily living, including dressing, grooming, personal hygiene, toileting, mobility, and escorting.

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 Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) _____ Date _____

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members provided care and services in accordance with the residents' negotiated service agreements for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure placed the residents at risk for decreased quality of life and their dignity not maintained.

Findings included…

Resident 1 (R1)

Review of R1's face sheet, dated 03/18/2025, showed the resident admitted to the facility on [redacted]/2023 with diagnosis including [redacted].

Review of R1's negotiated service plan, dated 01/18/2025, showed R1 was able to communicate effectively and make their needs known. R1 required staff assistance with her activities of daily living, including dressing, grooming, personal hygiene, toileting, mobility, and escorting.

On 03/18/2035 at 9:30 AM, R1 was observed in bed, covered with blankets and looking at the wall. R1's room had a very strong urine odor. R1 said she had not gotten out of bed on 03/18/2025 and would like to be assisted out of bed. R1 stated she was wet and felt uncomfortable.

During continuous observation on 03/18/2025 from 9:30 AM to 10:40 AM, no staff member entered R1's room.

In an interview on 03/18/2025 at 10:40 AM, Staff B, Medication Technician , said staff had not assisted R1 out of bed on 03/18/2025 and her incontinent products was last changed around 6:00 AM on 03/18/2025 by the night shift staff. Staff B stated R1 was dependent on staff members for assistance with her activities of daily living and incontinent care.

In an interview on 03/18/2025 at 10:52 AM, Staff C, Caregiver, stated she had not checked on R1 on 03/18/2025. Staff C said the resident had not gotten out of bed and did not have breakfast on 03/18/2025. Staff C said staff members were supposed to check and/or change the resident every two hours, before and/or after meals and the last incontinent care was provided by the night shift staff.

On 03/18/2025 at 10:58 AM, the Department's representative asked Staff C to check on R1. Staff C entered the resident's room and said the room had strong urine odor. Staff C checked R1's incontinent products and said the resident was wet. Staff C asked R1 if she would want to be assisted out of bed and R1 responded "Yes."

On 03/18/2025 at 11:00 AM, Staff C covered the resident with blankets and told the resident she needed to get another staff member to assist R1. Staff C exited R1's room and went to answer another resident's call light.

On 03/18/2025 at 11:20 AM, R1 was observed in bed, eyes opened and covered with blankets. The resident said staff had not changed her incontinent products and she was wet. At 11:40 AM and 11:50 AM, the resident was observed in bed, eyes opened and covered with blankets.

In an interview on 03/18/2025 at 12:00 PM, R1 said she was hungry and wanted to eat. R1 stated she was wet and felt uncomfortable.

On 03/18/2025 at 12:03 PM, Staff B was observed entered R1's room, checked the resident's incontinent products and said the resident was wet and soiled with bowel movement. Staff B said the resident's room had a smell of urine.

Resident 2 (R2)

Review of R2's face sheet, dated 03/18/2025, showed the resident admitted to the facility on [redacted]/2024 with diagnosis including [redacted].

Review of R2's negotiated service plan, dated 02/17/2025, showed R2's communication was mildly impaired. R2 required staff assistance with his activities of daily living, included toileting, dressing and escorting.

On 03/18/2025 at 10:30 AM, R2 was observed standing at the doorway of his room, dressed in street clothes and barefooted. R2 said he was looking for help, turned and walked to his bed.

On 03/18/2025 at 11:00 AM, R2 was observed walking out of his room and Staff D, Activity Assistant, told R2 to wait and she would look for someone to help.

In an interview on 03/18/2025 at 11:28 AM, R2 said he had waited for someone to help since he got up on 03/18/2025. R2 stated he did not have breakfast on the morning of 03/18/2025. R2 said he had waited for a long time.

On 03/18/2025 at 11:28 AM, Staff D was observed escorted R2 to the toilet. Staff D said R2 needed assistance with morning care, dressing and toileting.

On 03/18/2025 at 11:31 AM, Staff C was observed putting on the leg brace for R2 and changing R2's clothes. Staff C asked R2 if he had slept in his street clothes and R2 responded "Yes." Staff C said R2 had pajamas that he slept in, and staff did not change R2's clothes on the previous night.

In an interview on 03/18/2025 at 12:19 PM, Staff A, Resident Care Coordinator, said the facility's practice was to toilet the residents when they got up in the morning, before and/or after meals. Staff A stated the caregivers, and the medication technicians were responsible for ensuring care and services were being provided timely as documented in the residents' negotiated service plans. Staff A said she worked on the floor and routinely observed staff members and the residents to ensure care and services were being provided.

This was an uncorrected deficiency previously cited on 01/03/2025.

Statement of Deficiencies	License #: 2652	Compliance Determination # 56585
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 5 of 5	Licensee: CREF3 Oxford Living Sherwood LLC	03/18/2025

Plan/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, Sherwood Assisted Living is or will be in compliance with this law and / or regulation on (Date) 05/01/2025.

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

[signature], Administrator — 04/03/2025

Administrator (or Representative) — Date

Plan/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, Sherwood Assisted Living 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.

_____ _____

Administrator (or Representative) Date

Residential Care Services
Investigation Summary Report

Provider/Facility: Sherwood Assisted Living
Provider Type: Assisted Living Facility

License/Cert.#: 2652
Intake ID: 152078
Compliance Determination #: 51550
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 12/11/2024 through 01/03/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Report of resident leaving facility and being found outside and report of resident falling sustaining injury.
2. Admission, Transfer and Discharge Rights: Report of resident being charged after moving out of facility after sustaining an injury and not providing 30 days notice.

Investigation Methods:

Sample:	Total residents: 66 Resident sample size: 5 Closed records sample size: 3
Observations:	Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Facility policies progress notes Care plan Assessment

Investigation Summary:

Quality of Care/Treatment: Resident resided in Assisted living and would go outside. Resident was moved into memory care unit after incident of resident being found outside on property. After record review and interview, resident sustained injury after care plan was not followed. Failed practice identified.

Admission, Transfer and Discharge Rights: After interviewing family, family was not charged after resident was moved out of the facility. No failed practice identified.

Conclusion / Action:

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

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies Plan of Correction Page 1 of 4	License #: 2652 Sherwood Assisted Living Licensee: CREF3 Oxford Living Sherwood LLC	Compliance Determination # 51550 Completion Date 01/03/2025

You are required to be in compliance at all times with all licensing laws and regulations to maintain your Assisted Living Facility license.

The department completed data collection for an unannounced on-site complaint investigation on 12/11/2024 and 12/11/2024 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 152078, 158704

The following sample was selected for review during the unannounced on-site visit: 5 of 66 current residents and 3 former residents.

The department staff that investigated the Assisted Living Facility:

Pamela Horlick, NCI RN Complaint Investigator

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

Cory Cisneros
Residential Care Services

01/15/2025
Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

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From:
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800 NE 136th Ave Ste 200
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Residential Care Services

Date

I understand that to maintain an Assisted Living Facility license, the facility must be in compliance with all the licensing laws and regulations at all times.

Administrator (or Representative) Administrator Date 01/23/2025

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to implement and provide care as documented on the Service Plan (facility's version of the Negotiated Service Agreement) for 1 of 3 residents, (Resident 1 [R1]) reviewed. This failure contributed in R1 falling, developing in an inoperable injury, and placed all residents at risk for harm and unmet care needs.

Findings included...

Record review of facility's policy titled, "Negotiated Service Agreement", dated 10/16/2024, showed, "All residents will develop and document a negotiated service agreement outlining the scope of care for the resident. Residents are encouraged to participate. Residents or their responsible party are signed when there is a change to the negotiated service agreement but at least annually as well as a representative of Sherwood Assisted Living [sic]." Under the section titled, "Procedure," showed:
1. The negotiated service agreement will address the following at a minimum:
(a) The plan to monitor the resident and address interventions for current risks to the resident's health and safety that were identified in one or more of the following :
(i) The residents preadmission assessment;
(ii) The residents full assessments;
(iii) On going assessments of the resident;
(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;
(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
(d) The plan to provide necessary health support services, if provided by the assisted living facility;
(e) The resident's preferences for how services will be provided. Supported and accommodated by the assisted living facility.
Sherwood Assisted Living will provide care as addressed in the negotiated service agreement unless deviation to the negotiated services agreement is mutually agreed upon by the resident or their representative and the facility."

Review of R1's face sheet, dated 12/11/2024, showed that R1 was admitted to the

Administrator (or Representative) Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

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Findings included…

Record review of facility's policy titled, "Negotiated Service Agreement", dated 10/16/2024, showed, "All residents will develop and document a negotiated service agreement outlining the scope of care for the resident. Residents are encouraged to participate. Residents or their responsible party are signed when there is a change to the negotiated service agreement but at least annually as well as a representative of Sherwood Assisted Living [sic]." Under the section titled, "Procedure," showed:
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(i) The residents preadmission assessment;
(ii) The residents full assessments;
(iii) On going assessments of the resident;
(b) The plan to provide assistance with activities of daily living, if provided by the assisted living facility;
(c) The plan to provide necessary intermittent nursing services, if provided by the assisted living facility;
(d) The plan to provide necessary health support services, if provided by the assisted living facility;
(e) The resident's preferences for how services will be provided. Supported and accommodated by the assisted living facility.
Sherwood Assisted Living will provide care as addressed in the negotiated service agreement unless deviation to the negotiated services agreement is mutually agreed upon by the resident or their representative and the facility."

Review of R1's face sheet, dated 12/11/2024, showed that R1 was admitted to the

facility on [redacted]/2023.

Record review of R1's care plan, dated 09/24/2024, showed under "mobility/Ambulation," the "goal" showed, "Resident will maintain and/or maximize current level of functioning with mobility/ambulation. Under "action," it listed, "wheelchair (electric, manual)".

Record review of R1's progress notes, date range 08/07/2024 through 12/11/2024, showed the following:

-[redacted]/2024- Resident was awake multiple times, wheeling themself out of their room and towards the back door.

-[redacted]/2024- Resident moved from Assisted living to the memory care unit. They are in a wheelchair and ambulates using their feet in wheelchair.

-08/12/2024- Resident continues to wake up throughout the night and wheel themself out of their room.

-08/29/2024- Resident cruising around hallways in wheelchair per their usual day shift routine

-09/13/2024- Resident had been up in wheelchair and at meals when they weren't napping. Resident had their per usual cat nap in wheelchair in hallway.

-09/25/2024- Resident remained in room most of the night, observed to be "wandering" for an hour or so in memory care unit hallway in wheelchair.

In an interview on 12/11/2024 at 12:37 PM, Staff B, Caregiver, was asked if R1 used a walker, they stated he always used a wheelchair.

In an interview on 12/11/2024 at 12:52 PM, Staff C, Caregiver, was asked if they were familiar with R1, they stated yes. Staff C stated they were told R1 had a fall when they were in the dining room with a walker. Staff C stated R1 was usually in a wheelchair.

Record review of R1's fall report, dated 10/14/2024, showed that R1 was attempting to sit at a table for dinner and fell. On the report, it asked, "Does the resident use assistive devices," the "yes" box was checked and typed in next to the boxes showed "4 wheeled walker." On the second page there was a box for additional comments. It showed, Resident was ambulating with their walker into the dining room. LN [Licensed Nurse] heard a loud noise. Caregiver witnessed the fall. Resident went to turn and sit down at a

table. Their feet got tangled and they lost their balance and fell.

Record review of hospital discharge paperwork, dated [redacted]2024, showed a CT (Computed tomography) scan that showed R1 was found to have acute nondisplaced fracture of the right superior and inferior pubic rami (a recent, stable break in both the upper and lower portions of the right pubic bone in the pelvis, where the bones are not shifted out of place). Note further states that this injury was "nonoperative."

In an interview on 12/11/2024 at 1:20 PM, Staff A, Executive Director, was asked, what mobility devices was R1 care planned to use, Staff A stated a wheelchair. Staff A was asked if R1 was able to use a walker, they stated no, they were just care planned to use a wheelchair. Staff A stated, there was nothing in the recent care plan about using a walker, if there was it would be under mobility and ambulation. Staff A stated, they just don't see it.

Plan/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, Sherwood Assisted Living is or will be in compliance with this law and / or regulation on (Date) 02/14/2025.

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

Administrator, Administrator
Administrator (or Representative)

01/23/2025
Date

table. Their feet got tangled and they lost their balance and fell.

Record review of hospital discharge paperwork, dated [redacted]/2024, showed a CT (Computed tomography) scan that showed R1 was found to have acute nondisplaced fracture of the right superior and inferior pubic rami (a recent, stable break in both the upper and lower portions of the right pubic bone in the pelvis, where the bones are not shifted out of place). Note further states that this injury was “nonoperative.”

In an interview on 12/11/2024 at 1:20 PM, Staff A, Executive Director, was asked, what mobility devices was R1 care planned to use, Staff A stated a wheelchair. Staff A was asked if R1 was able to use a walker, they stated no, they were just care planned to use a wheelchair. Staff A stated, there was nothing in the recent care plan about using a walker, if there was it would be under mobility and ambulation. Staff A stated, they just don’t see it.

Plan/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, Sherwood Assisted Living 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.

_____ _____

Administrator (or Representative) Date