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

05/12/2025

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) 59574 (Completion Date 05/12/2025) and 56586 (Completion Date 03/18/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/12/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**WAC 388-78A-2450 Staff.**

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(2) The assisted living facility must:

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

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

If you have any questions, please contact me at (253)254-3190.

Sincerely,

Cory Cisneros

Cory Cisneros, 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 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 # 566586 |
|---|---|---|
| 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)

04/03/2025
Date

**WAC 388-78A-2450 Staff.**

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(2) The assisted living facility must:

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the assisted living facility failed to provide sufficient staff persons to assist residents with care and services in a timely manner for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure placed residents at risk for experiencing distress, unmet care needs, and decreased quality of life.

Findings included...

Review of the assisted living facility's resident characteristic roster, dated 03/18/2025, showed there were 17 residents residing in the memory care unit. All seventeen residents required assistance with activities of daily living and sixteen of the resident's required assistance with medication administration. Seven residents needed moderate level of care, and two residents required maximum level of care.

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)

Date

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(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the assisted living facility failed to provide sufficient staff persons to assist residents with care and services in a timely manner for 2 of 4 sampled residents (Resident 1 and Resident 2) reviewed. This failure placed residents at risk for experiencing distress, unmet care needs, and decreased quality of life.

Findings included...

Review of the assisted living facility's resident characteristic roster, dated 03/18/2025, showed there were 17 residents residing in the memory care unit. All seventeen residents required assistance with activities of daily living and sixteen of the resident's required assistance with medication administration. Seven residents needed moderate level of care, and two residents required maximum level of care.

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 the resident 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 observations 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 Tech, 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. Staff B said there was one caregiver and her for 15 residents in the memory care unit. Staff B stated they did their best to assist the residents and "It's difficult."

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 R1 had not gotten out of bed and did not have breakfast. Staff C stated she was the only caregiver in the memory care unit, some residents required two staff members for assistance with transfer, and she had to help serve breakfast. Staff C said she did not have time to check on R1. Staff C said staff members were supposed to check and/or change the resident every two hours, before and/or after meals. Staff C stated the assisted living facility did not have sufficient staff to assist the residents.

On 03/18/2025 at 10:58 AM, the Department's representative asked Staff C to check on R1. Staff C entered R1'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 the call light in another resident's room.

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

In an observation and interview on 03/18/2025 at 12:03 PM, Staff B entered R1's room, checked R1's incontinent products and said R1 was wet and soiled with bowel movement. Staff B said R1'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, including 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.

In an observation and interview on 03/18/2025 at 11:28 AM, Staff D 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.

| Statement of Deficiencies | License # 2652 | Compliance Determination # 55586 |
|---|---|---|
| Plan of Correction | Sherwood Assisted Living | Completion Date |
| Page 5 of 5 | Licensee: CREF3 Oxford Living Sherwood LLC | 03/18/2025 |

In an interview at 11:39 AM, Staff D said R2 asked for help earlier, she looked and the staff members were busy. Staff D stated R2 needed assistance, both Staff B and Staff C were busy, so she decided to assist the resident. Staff D said there were not enough staff members to assist the residents.

In an interview on 03/18/2025 at 11:58 AM, Collateral Contact 1 (CC1), a caregiver not associated with the facility and wished to remain anonymous and not to have the resident named, stated they came in five days a week to assist the resident with care, dressing and escort the resident to meals. They said the staff members were excellent, worked hard, busy, and caring but there were just two of them and that was not enough. They stated they were not able to provide all the care for the resident and some tasks they needed staff assistance and often waited 30 to 40 minutes when summoned staff for assistance.

Observations from 9:30 AM to 12:15 PM on 03/18/2025 showed Staff B and Staff C were the two care staff members in the memory care unit. Staff B and Staff C were observed to be providing non-stop care for the residents.

In an interview on 03/18/2025 at 12:19 PM, Staff A, Resident Care Coordinator, said the assisted living facility did not have a policy and procedures to instruct staff members how often the residents should be toileted, checked and/or changed. Staff A stated the facility's practice was to toilet the residents when they got up in the morning, before and/or after meals. Staff A said residents who required more frequent toileting assistance would be documented in their negotiated service plan. Staff A stated the caregivers, and the medication technicians were responsible for ensuring care and services were being provided timely for residents. Staff A said the facility's corporation dictated the staffing schedule and the assisted living facility was allowed one caregiver and one medication technician per shift in the memory care unit.

This was an uncorrected deficiency previously cited on 01/24/2025.

**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.

Administrator (or Representative) (Administrator) 04/03/2025 Date

In an interview at 11:39 AM, Staff D said R2 asked for help earlier, she looked and the staff members were busy. Staff D stated R2 needed assistance, both Staff B and Staff C were busy, so she decided to assist the resident. Staff D said there were not enough staff members to assist the residents.

In an interview on 03/18/2025 at 11:56 AM, Collateral Contact 1 (CC1), a caregiver not associated with the facility and wished to remain anonymous and not to have the resident named, stated they came in five days a week to assist the resident with care, dressing and escort the resident to meals. They said the staff members were excellent, worked hard, busy, and caring but there were just two of them and that was not enough. They stated they were not able to provide all the care for the resident and some tasks they needed staff assistance and often waited 30 to 40 minutes when summoned staff for assistance.

Observations from 9:30 AM to 12:15 PM on 03/18/2025 showed Staff B and Staff C were the two care staff members in the memory care unit. Staff B and Staff C were observed to be providing non-stop care for the residents.

In an interview on 03/18/2025 at 12:19 PM, Staff A, Resident Care Coordinator, said the assisted living facility did not have a policy and procedures to instruct staff members how often the residents should be toileted, checked and/or changed. Staff A stated the facility's practice was to toilet the residents when they got up in the morning, before and/or after meals. Staff A said residents who required more frequent toileting assistance would be documented in their negotiated service plan. Staff A stated the caregivers, and the medication technicians were responsible for ensuring care and services were being provided timely for residents. Staff A said the facility's corporation dictated the staffing schedule and the assisted living facility was allowed one caregiver and one medication technician per shift in the memory care unit.

This was an uncorrected deficiency previously cited on 01/24/2025.

**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)_____ .

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:** 161065
**Compliance Determination #:** 52809
**Region/Unit #:** RCS Region 3 / Unit E
**Investigator:** Pamela Horlick
**Investigation Date(s):** 01/09/2025 through 01/24/2025
**Complainant Contact Date(s):**

**Allegation(s):**

1. Infection Control: Report of infectious disease in the facility.
2. Resident/Patient/Client Neglect: Report of residents not being showered or getting bed changes and concerns about staffing.
3. Physical Environment: Report of Bed changes for residents not happening.
4. Nursing Services: Report of residents being transferred without 2 people minimum.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 63<br>Resident sample size: 7<br>Closed records sample size: 1 |
| **Observations:** | Residents<br>Identified resident<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>Identified staff<br>Nursing staff<br>Residents<br>LHJ-Summer Richardson<br>Executive Director |
| **Record Reviews:** | State reporting log<br>Characteristic Roster<br>List of residents with flu<br>Staff working schedule<br>Incident Log<br>Progress notes<br>assessments<br>Care Plans<br>Email with LHJ |

**Investigation Summary:**

1. Facility contacted LHJ for guidance. Staff adhered to hand hygiene and mask use. Facility made notifications and monitored residents. No failed practice identified.
2. Sampled residents denied missing showers and bed changes. No failed practice identified. Facility failed to follow policy to ensure both Assisted living unit and memory care unit were staffed at all times. Failed practice identified.
3. Sampled residents voiced no concerns related to bed changes. No failed practice identified.
4. Report of residents being transferred without 2 people present. This has been addressed in statement of deficiency dated 01/03/2025.

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**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***



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 01/09/2025 and 01/28/2025 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 161065, 159707

The following sample was selected for review during the unannounced on-site visit: 7 of 63 current residents and 1 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

02/05/2025
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)

02/07/2025
Date

**WAC 388-78A-2450 Staff.**

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(2) The assisted living facility must:

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

**This requirement was not met as evidenced by:**

Based on interview and record review, the facility failed to ensure they had sufficient staff to meet resident needs for 2 of 2 units (memory care unit and assisted living unit) reviewed. This failure resulted in memory care unit being left unattended during an incident and placed all 63 of 63 residents at risk for unmet care needs and safety issues.

Findings included...

Record review of Department of Social and Health Services Dear Provider Letter, dated 10/31/2024, showed "the purpose of this letter is to remind providers and facilities when it is appropriate for facilities to call emergency medical services (EMS) or 911...As you may know, emergency departments have reached record high wait times and EMS

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

02/05/2025
Date

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**This requirement was not met as evidenced by:**

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Findings included…

Record review of Department of Social and Health Services Dear Provider Letter, dated 10/31/2024, showed "the purpose of this letter is to remind providers and facilities when it is appropriate for facilities to call emergency medical services (EMS) or 911…As you may know, emergency departments have reached record high wait times and EMS

crews are becoming increasingly overburdened. The unintended consequences of these statistics can result in negative resident outcomes. We encourage each facility to be proactive in planning each resident/clients care and explore resources that can help support the residents/clients and community. This can include reviewing and implementing:

-Resident/client goals for treatment, advanced directives, and specifics listed on the physician orders for Life-Sustaining Treatment (POLST)form;
-Use of mobile x-ray, onsite urgent care, physician consult/visits, etc;
-EMS usage in policies, procedures, and long standing practices;
-Best practices for before, during, and after a resident/client-focused 911 call; and
-Expectations to best serve resident/clients, staff, EMS, hospitals, and community resources

Please review relevant state laws and rules pertaining to your responsibilities related to resident/clients, their medical issues, and the use of the local fire department and emergency medical services (EMS) or 911. Please remember that you are required to have sufficient and trained staff, equipment, and supplies at all times to respond to resident/client needs, including medical emergencies.

The staff must be capable of:
-Evaluating the resident/clients condition ongoing:
-Assisting the resident/client back to the pre-fall position if there are no signs of injuries; and
-Providing the EMS team with sufficient information on the resident's condition and observed acute changes when making the 911 call and upon arrival of the EMS

LTC [Long Term Care] facilities are encouraged to:
-utilize alternatives to an ER [Emergency Room] visit, such as mobile x-ray, onsite urgent care, or physician consult/visits, etc
-Use the guidance and educate staff and residents for when EMS is called, included in the Dear Provider Letter
-Be proactive when identifying, meeting, and addressing medical and mental health needs.

Please note that the EMS team can independently determine whether or not the transfer to the hospital is appropriate depending on their evaluation of the resident and/or medical information presented to them by facility staff. This can result in a possible denial to transfer the resident to the hospital if they feel it is not medically necessary, and the resident is stable. Facility staff are not required to have EMS sign a document stating they are denying the transfer. Instead, a written statement in the resident record is sufficient.

EXAMPLES WHEN TO CALL 9-1-1:
- Has an acute/serious, life-threatening medical condition or complaint. A medical

emergency can be defined as something that will result in loss of life or limb if not treated immediately.
-Is medically unstable; or
-Has an immediate health risk.
-Examples can include:
- Head injury with change of mental status;
-Large burn or cut that will not stop bleeding;
-Trouble breathing- unable to speak in full sentences; or
-First time or longer than normal seizure.

EXAMPLES WHEN NOT TO CALL 9-1-1:
-The resident/client is medically stable;
-Health status is non-acute or not serious.
-Fall that did not result in obvious injury or mental status change;
-Need of medication or supplies that the facility is required to have/complete on site.

This letter does not mean that you should never call 9-1-1. When your evaluation or assessment of the resident shows that the resident may have a medical emergency, you should call 9-1-1. Please refer to the guidance below when calling 9-1-1."

Review of Department records showed that a report was made on 12/31/2024 at 1:06 AM notifying the Department of critical staffing shortages where only 2 people were staffed in the building during NOC (night) shift. The report stated that caregivers were barely able to toilet all of the residents and staff had been injured and were out on L and I (Labor and Industries- work place injury services) due to having to transfer residents that required two person assist to transfer.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," dated 01/09/2024, showed 13 residents resided in the memory care unit. Of those 13 residents, 1 required maximum assistance and 5 required moderate assistance with ADL's (Activities of Daily Living). Of those 13 residents in memory care, 7 were documented to have "dementia/Alzheimer's/ cognitive impairment." (Dementia is a general term that describes a group of symptoms that affect cognitive function, memory, language, and behavior and Alzheimer's is a disease in the brain, whereas dementia is a collection of symptoms).

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection ," dated 01/09/2025, showed 50 residents resided in the Assisted living unit. Of those 50 residents, two required maximum assist with ADL's and 11 required moderate assistance with ADL's .

In an interview on 01/16/2025 at 1:12 PM, Staff A, Executive Director, was asked what room numbers on the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," were rooms in the memory care unit, Staff A stated, rooms 101-112, 1A-8B and suite A and B. Staff A stated, rooms 117-308 were

Assisted Living Unit rooms. Staff A was asked what "max" assist on the document meant, they stated, it meant the resident required two person assist with transfers and mobility, usually a hoyer lift (a mechanical device to transfer a person) was needed.

Resident 1 (R1)

Record review of R1's face sheet, dated 01/09/2025, showed that R1 admitted to the facility on [redacted]/2023.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," dated 01/09/2025, showed R1 resided in the Assisted Living Unit of the facility.

Record review of facility document titled "Fall Report," dated 12/18/2024 at 1:53 AM, showed, R1 used the call pendant for assistance. Staff C, Medication Technician, arrived to find R1 on the floor. R1 denied head strike and denied injury, only mentioning that their knee was sore. A caregiver arrived to help transfer R1 from the floor into recliner chair. Resident was inspected for injury with none noted.

Record review of R1's progress notes, dated 12/15/2024-12/19/2024, showed:

-12/15/2024 9:45 AM: POA [Power of Attorney] was contacted regarding R1's fever and positive for Influenza type A
-12/16/2024 5:45 AM: R1 still not feeling well. R1 showing signs and symptoms of Flu (diarrhea, weakness, and coughing). Resident needed maximum assistance with transferring and toileting on this NOC shift.
-12/17/2024 5:30 AM: Resident still weak before bed and required assistance with getting up and to the bathroom.
-12/18/2024 3:00 PM: No latent injuries from fall on 12/18/2024.
-12/19/2024 6:15 PM: R1 expressed discomfort from their knee. R1 was able to transfer slowly with some assistance.

In an interview on 01/16/2025 at 3:24 PM, Staff C was asked if there had been any incidents that had occurred on NOC (night) shift where they needed help from other staff, they stated, yes they have had to call the caregiver in the memory care unit to help them. Staff C, stated, Staff D, caregiver, left the memory care unit unattended to help them. Staff C stated they have had to leave the Assisted Living Unit unattended to administer medications in the memory care unit before for at least 30 minutes. Staff C stated there have been many incidents that have occurred resulting in needing help from the caregiver scheduled in memory care. Staff C stated, they had to call Staff D to

leave memory care to help them in Assisted Living when R1 was found on the floor in their room. Staff C was asked how long Staff D was there to help them, they stated 5-10 minutes.

In an interview on 01/15/2025 at 6:25 PM, Staff D was asked if they recall a fall R1 had about a month ago, they stated they work in memory care and there were several falls that happened a month ago. Staff D stated they recall having to go help a staff member when R1 was found on the floor. Staff D stated it was fairly common that staff get called to help on the other side of the building. Staff D was asked if the memory care unit was left unattended, they stated yes because there was an emergency. Staff D was asked what the process was when an incident occurred, they stated, they grab their radio and inform the medication technician (med tech) to come help. Staff D stated we want the med tech present at all times. The med tech will determine if they were injured. Staff D was asked if it was acceptable to leave their unit unattended, they stated, no, its not.

In an interview on 01/28/2025 at 12:28 PM, Collateral Contact 2 (CC2), Medication Technician, stated they had voiced concerns several times that more help was needed so that they were covered and could provide proper care. CC2 stated it was difficult to provide safe care while providing privacy with the door shut and be able to hear an alarm. CC2 stated there were multiple times there were just two staff in the building over the past four weeks. CC2 stated they cant even take a break, there was not enough staff. CC2 was asked if there were residents in the memory care unit that required two person assist, they stated yes and we make arrangements for the Assisted Living unit med tech to come over to assist the residents. CC2 stated, Resident 2 (R2) required two person assist due to them being heavy in care needs. CC2 stated they have had to call for assistance from the AL (Assisted Living) med tech in the past to come assist with care. CC2 was asked if they came over to help, they stated, yes they didn't have a choice. We were the only ones on shift that night. CC2 was asked how long Assisted living was left unattended, they stated, 5-10 minutes.

<R2>

Record review of R2's face sheet, dated 01/09/2025, showed that R2 admitted to the facility on [redacted]/2023.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection," dated 01/09/2025, showed, R2 resided in the Memory care unit.

Record review of R2's Service Plan (Negotiated Service Agreement), dated 12/30/2024, under the section "Toileting" showed "Level of assistance-Toileting: Total. Resident requires physical assistance with all tasks related to toileting."

In an interview on 01/09/2025 at 1:13 PM, R2 was asked why they were moved from

Assisted living to the memory care unit, they stated, they were told that they required more care than what they can give on assisted living side. R2 was asked if they have concerns with staffing, they stated yes, on Assisted Living they don't seem to have enough staff. R2 stated when I called for help, they weren't prompt.

In an interview on 01/08/2025 at 3:18 PM, Collateral Contact 1, Medication Technician, stated staff were hurt while transferring R2. CC1 stated the culture was to do it if you can. CC1 stated R2 was then transferred to memory care. CC1 stated R2 expressed they didn't understand why they were transferred to memory care.

In an interview on 01/16/2025 at 3:29 PM, Staff B, Resident Care Manager was asked if R2 was a two person assist with toileting, they stated yes, but at night they are in bed and they are a check and change. Staff B stated R2 just required one person at night.

In an interview on 01/24/2025 at 3:20 PM, Staff E, Medication Technician, was asked if they work night shift, they stated they work both night shift and day shift. Staff E was asked what they do at night when they need to provide care to R2, they stated they ask a caregiver to help them. Staff E stated R2 used to be a lot more mobile, but now they are a two person transfer. Staff E stated R2 was a "2 person everything." Staff E was asked what they do at night when they need to get R2 up, they stated, we were trained to get help. Staff E stated we change R2 about 3-4 AM when they are in bed. We do not use a lift, but we use two people. Staff E stated R2 used to sleep in their chair and recently they just started sleeping in their bed. When they slept in their chair we would have to use a lift and we would use two people to get them up. Staff E was asked if that happened on NOC (night) shift, they stated yes, its standard procedure anytime we toileted them.

Record review of R2's progress notes, dated 12/23/2024-01/06/2025, showed:

-12/23/2024 at 12:45 PM, R2 had a very loose bowel movement in the bed in the morning and it required a full bed change. Staff E wrote they were injured during the process while fully supporting R2's weight while providing care.

- 12/26/2024 12:15 PM, R2 was moved to the memory care unit due to heavier cares and needing more assistance with ADL's (Activities of Daily Living). Resident will be able to get more detailed care.

- 12/28/2024 at 5:30 AM, R2 expressed that they didn't want to be in memory care and that she doesn't like it.

-01/06/2025 at 4:45 AM, R2 expressed confusion and sadness and asked why they were moved to the memory care unit. R2 understands that they need more care but doesn't understand why those cares couldn't be provided for in the Assisted Living Unit. Please

monitor for continued signs of depression and distress.

Resident 3(R3)

Record review of R3's face sheet, dated 01/09/2025, showed that R3 admitted to the facility on [redacted]/2024.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection ," dated 01/09/2025, showed R3 resided in the Assisted Living Unit.

Record review of R3's Service Plan (Negotiated Service Agreement), dated 04/11/2024, under the section "Toileting" showed "Level of assistance-Toileting: Total."

In an interview on 01/09/2025 at 11:27 AM, R3 was asked if they were getting the services they pay for, they stated, it could be better. R3 was asked what could be better, they stated, more help, the aides are nice but they don't have the help. R3 stated they call to go to the bathroom and nobody comes. R3 was asked what they do, they stated they sit and wait. R3 stated it took almost two hours before someone came, it happened often.

Resident 4 (R4)
Record review of R4's face sheet, dated 01/09/2025, showed that R4 admitted to the facility on [redacted]/2020. Listed under "Diagnoses" showed "[redacted]."

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection ," dated 01/09/2025, showed R4 resided in the Assisted Living Unit.

Record review of R4's Service Plan (Negotiated Service Agreement), dated 10/25/2024, under the section "Toileting" showed "Beside commode" and "Level of assistance-Toileting: Moderate. Resident requires stand by assistance for toileting tasks." Under the section, titled, "Transferring," showed "grab bar" and "level of assistance-transferring: Total. Resident requires routine hands on assistance with transfers and/or changes in position."

In an observation and interview on 01/09/2025 at 2:38 PM, R4 was observed to have had their [redacted]. R4 was asked if staff come to help assist them when they hit their call light, they stated yes, sometimes it takes awhile. R4 was asked

if they ever have soiled themselves waiting, they stated yes, it happened often. R4 was asked how that made them feel when that happened, they stated, "it happens, there is nothing I can do about it."

Resident 5(R5)

Record review of R5's face sheet, dated 01/09/2025, showed that R5 admitted to the facility on [redacted]/2024.

Record review of the facility document titled, "Assisted Living Facility Resident Characteristic Roster and Sample Selection ," dated 01/09/2025, showed R5 resided in the Memory Care Unit.

Record review of R5's Service Plan (Negotiated Service Agreement), dated 01/03/2025, under the section "Toileting" showed, "Resident will maintain and/or maximize current level of functioning with toileting. Assist resident to the bathroom, allow his privacy and remind him to use the pull cord when he is finished. Assist as needed with clean up" and "Level of assistance-Toileting: Moderate. Resident requires stand by assistance for toileting tasks." Under the section, titled, "Transferring," showed "resident will maintain and/or maximize current level of functioning with transferring" and "level of assistance-transferring: Extensive. Resident requires frequent hands-on assistance with transfers and/or change in position."
In an interview on 01/09/2025 at 12:08 PM, R5 was asked if staff come help them when they call for help, they stated sometimes. R5 stated they have no way of tracking the time because they were blind. R5 stated about a week ago they called staff to use the toilet for a bowel movement, staff didn't come so they soiled themself. R5 was asked how that made them feel, they stated they had gotten used to it and they had accepted it. R5 was asked why they were moved to the memory care unit, they stated [the facility] decided that the care level was not quite high enough in the assisted living unit. R5 was asked if they have been diagnosed with dementia or Alzheimer's, they stated no. R5 was asked if they voiced that they didn't want to be in memory care, they stated no, as opposed to assisted living, they were short staffed but did the best they could.

Record review of R5's progress notes, dated 01/06/2025, showed:

-01/06/2025 at 4:45 AM, R5 was placed on alert to monitor for depression. Since moving to memory care unit caregivers have reported that R5 was not his normal "self" and that he wasn't eating much as he normally did on the assisted living side. R5 to be monitored for depression and distress.
-01/06/2025 10:45 AM, R5 seems to be in a mental fog. Resident feels lonely.

During a records request on 01/09/2025 at 4:20 PM, a policy on staffing was requested.
Record review of an email sent on 01/09/2024 at 6:54PM, Staff B stated, they spoke with Staff A about a staffing policy for the facility and there wasn't one.

Review of the facility staffing schedule, dated December 2024, showed the following were the actual worked staff for NOC (night) 10pm-6:30am shift:

December 12th, 2024
-1 med tech in Assisted living and 2 caregivers in memory care. Total 3 staff.

December 14th, 2024
-1 med tech in assisted living and 2 caregivers in memory care. Total 3 staff.

December 15th, 2024
-1 med tech in assisted living and 2 caregivers in memory care. Total 3 staff.

December 16th, 2024
-1 med tech in assisted living and 2 caregivers in memory care. Total 3 staff.

December 17th, 2024
-1 med tech in assisted living and 1 caregiver in memory care. Total 2 staff.

December 18th, 2024
-1 med tech in assisted living until 6 am and 1 caregiver in memory care. Total 2 staff.

December 20th, 2024
-1 med tech in assisted living and 1 caregiver in memory care. Total 2 staff.

December 21st, 2024
-1 med tech in assisted living and 1 caregiver in memory care. Total 2 staff.

December 30th, 2024
-1 med tech in assisted living and 1 caregiver in memory care. Total 2 staff.

Review of a staffing schedule, dated December 2024, showed the following were the actual worked staff for Evening 2pm-10:30pm shift:

December 14th, 2024
-2 med techs and 1 caregiver in assisted living and 1 med tech and 1 caregiver in memory care

December 16th, 2024
-1 med tech and 1 caregiver in assisted living and 1 med tech and 2 caregivers in memory care

December 17th, 2024
-2 med tech and 1 caregiver in assisted living and 1 med tech and 1 caregiver in memory care

In an interview on 01/09/2025 at 4:20 PM, Staff A, Executive Director, was asked what staffing was like for day shift, they stated, there were two med techs in assisted living and one in memory care, there were two caregivers in assisted living and two caregivers in memory care. The day shift med techs worked 12 hour shifts therefor covering evening shift. In the evening there were two caregivers in assisted living and two in memory care and for NOC (night) shift, they stated there was one med tech for the building and 3 caregivers for the whole building. Staff A was asked if there were staff in each unit at all times, they stated yes. Staff A was asked what their policy stated regarding staffing, they stated, we always have to have someone on both sides of the building. Staff A stated someone could have fallen and were calling out, we want to be circling the building and make sure someone was on each side. Staff A was asked what the process was when an incident like a fall were to occur, they stated, if the caregiver finds them they will call on the radio right away for help. When the help arrives, if it's a nurse they will do an assessment and if it's a med tech they will do vitals and call 911 if needed. When asked what do they do when there was only one other staff member in the building, they stated, that other caregiver needs to go there right away to help and they need to work together as a team. Staff A was asked if it was ok to leave memory care unit or assisted living unit unattended, they stated no. Staff A was asked, how was it possible for that caregiver and med tech to work together if they are not allowed to leave their unit, they stated, that's why we don't want just two staff. Staff A was asked if there were only two people in the building the night of the 17th when R1 fell, they stated, yes that's what it looks like. Staff A was asked if that was enough staff to provide the care to the residents in case of an emergency, they stated, its concerning.

In an interview on 01/16/2025 at 3:29 PM, Staff B, Resident Care Manager, was asked what staffing was like on the night shift from 10:00PM-6:30 AM on December 17th, they stated, Staff C and Staff D were on shift to cover the assisted living unit and the memory care unit. Staff B stated we couldn't get anybody to come in and help. Staff B was asked what happened with the fall R1 had early morning on December 18th, they stated R1 was trying to get up and they fell. They didn't have any injuries. Staff B was asked who came to help R1, they stated the med tech. Staff B was asked if there was a second person there, they stated there was. Staff B stated the med tech should have called 911. The med techs were trained to call 911. Staff B was asked if the incident required a call to 911, they stated, R1 could have pulled something in their leg. Staff B stated if there was only one med aid, they were to call 911 to help get the resident off the floor. Staff B was asked if memory care unit was left unattended, they stated yes. Staff B was asked if staffing was insufficient that night, they stated, no, if the caregiver left the floor it would have been less then three minutes and they would have gone straight back to the unit. Staff B was asked if there was a policy that the caregiver was to call 911 when there was only one other staff member in the building, they stated no,

its just an unwritten rule but we will be making a policy.

**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) 03/07/2025.

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

Administrator (or Representative) — Administrator

02/07/2025
Date

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**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