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

04/02/2025

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) 57325 (Completion Date 04/02/2025) and 53964 (Completion Date 02/10/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/02/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

The Department staff who did the On Site verification:
Paul Aube, ALF NCI

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2652
Intake ID: 163954
Compliance Determination #: 53964
Region/Unit #: RCS Region 3 / Unit E
Investigator: Paul Aube
Investigation Date(s): 01/30/2025 through 02/10/2025
Complainant Contact Date(s):

Allegation(s):

1. Quality of Care/Treatment: Public report of facility failing to provide care and services as agreed upon in the negotiated service agreement.
2. Fraud/False Billing: Public report of facility billing for services not which are not provided.
3. Infection Control: Public report of an outbreak of Norovirus in the Assisted Living Community.

Investigation Methods:

Sample:	Total residents: 63 Resident sample size: 5 Closed records sample size: 1
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Family members Housekeeping staff Management Local Health Jurisdiction
Record Reviews:	Facility policies Negotiated Service Agreements Nursing Assessments Progress Notes/Alert Charting

Investigation Summary:

1. Quality of Care/Treatment: Facility failed to provide services as agreed upon per the resident negotiated service plan. Failed practice identified. This issue was previously addressed under Statement of Deficiencies dated 12/03/2024, and the facility is in their plan of correction phase to address non-compliance.

2. Fraud/False Billing: Insufficient evidence to support claims of false billing.
3. Infection Control: Facility failed to consult and implement recommendations as set forth by the Local Health Jurisdiction during an outbreak, failed to provide staff the necessary supplies to prevent and limit the spread of infection, and failed to perform proper hand hygiene after providing resident care. 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

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 01/30/2025 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 161247, 163954

The following sample was selected for review during the unannounced on-site visit: 5 of 63 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Paul Aube, ALF NCI

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 # 539864
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 2 of 8	Licensee: CREF3 Oxford Living Sherwood LLC	02/10/2025

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.

Jody Just
Residential Care Services

02/19/2025
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
Administrator (or Representative)

02/27/2025
Date

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(d) Provide all resident care and services according to current acceptable standards for infection control;

(f) Report communicable diseases in accordance with the requirements in chapter 246-100 WAC.

This requirement was not met as evidenced by:

Based on observation, record review, and interview, the facility failed to implement proper infection control practices while in an outbreak status for 1 of 1 facility reviewed. The facility also failed to provide necessary supplies for employees to prevent and limit the spread of infection and failed to perform proper hand hygiene after providing resident care. The facility also failed to report in a timely manner and cooperate with the Local Health Jurisdiction. These failures placed all 63 of 63 residents at risk for spread of infectious disease.

Findings included...

WAC 246-100-021 Responsibilities and duties—Health care providers.
"Every health care provider, as defined in chapter 246-100 WAC, shall: (1) Provide adequate, culturally and linguistically appropriate, and understandable instruction in control measures designed to prevent the spread of disease to: (a) Each patient with a

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Residential Care Services | Date

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Administrator (or Representative) | Date

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communicable disease under their care; and (b) Others as appropriate to prevent spread of disease. (2) Cooperate with public health authorities during investigation of: (a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and (b) An outbreak or suspected outbreak of illness."

According to the Centers of Disease Control (CDC) article titled "About Norovirus" last reviewed on 04/24/2024, it stated, Norovirus is a very contagious virus that causes vomiting and diarrhea. It is sometimes called the "stomach flu" or the "stomach bug." However, norovirus illness is not related to the flu. The flu is caused by the influenza virus. Norovirus causes acute gastroenteritis, an inflammation of the stomach or intestines. Most people with norovirus illness get better within 1 to 3 days; but they can still spread the virus for a few days after."

According to the CDC article titled "Norovirus Outbreaks," last reviewed on 02/02/2025, it stated "A norovirus outbreak is defined as: An occurrence of two or more similar illnesses resulting from a common exposure that is either suspected or laboratory-confirmed to be caused by norovirus."

According to the CDC article titled "Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Health Care Settings," last reviewed on 04/12/2024, it stated, "Actively promote adherence to hand hygiene among healthcare personnel, patients, and visitors in patient care areas affected by outbreaks of norovirus gastroenteritis… During outbreaks, use soap and water for hand hygiene after providing care or having contact with patients suspected or confirmed with norovirus gastroenteritis."

Facility policy titled, "Infection Control," last reviewed on 03/07/2018, under the section "Hand Washing" it stated,
"1. After personal body function, use of toilet, blowing or wiping nose, smoking or combing the hair.
2. After handling soiled laundry or items with body fluids and housekeeping tasks.
3. Before handling medication.
4. Before and after helping residents with personal care tasks of daily living.
5. Before handling any food.
6. Whenever you change from doing a "dirty" task to a "clean" task.
7. Upon reporting on and off duty.
8. Dietary employee's hands must be washed at the kitchen sink upon reentry in the kitchen.
9. Before and after leaving for and returning from break periods and meals.
10. Whenever hands are obviously soiled.
11. When in doubt, wash!"
In the section "Managing and Reporting Communicable Disease" it stated, "2. Diseases classified as "reportable" according to chapter 246-101WAC and/or the requirements of the County Health Department will be reported accordingly."

In an interview with Collateral Contact 1 (CC1), Resident 1's (R1) representative, on

01/29/2025 at 12:28PM they stated, “The facility has had a significant Norovirus outbreak.” CC1 was asked if they had any concerns regarding the facility, and their response to the outbreak. CC1 stated, they were staying with R1 after they were found to be sick and exhibiting signs and was told by facility staff that it was Norovirus. CC1 stated, “I had to use the facilities restroom. I used gloves. I used the bathroom, and I go to wash my hands and there is no soap in the soap dispenser. One of the caregivers a few days before had told me, I don’t remember who it was, they had brought up to Staff B, (the Resident Care Manger [RCC]) that there were quite a few rooms where there was no soap in them.” CC1 was asked what they did at that point. CC1 stated, “I rinsed my hands with water, it was all I could do.” CC1 stated that they exited the bathroom and notified a caregiver that there was no soap in the bathroom and stated, “Then they brought me a bar of soap.” CC1 stated, “The next day I returned to R1’s room and there was still no soap in the dispenser. I asked the receptionist if there was anything they could do. I had to leave, but later R1 told me that they had come and put soap in the soap dispenser.” CC1 stated they had other concerns with infection control in the building. CC1 stated, “They were still serving meals in their rooms yesterday 01/29/2025, but today 01/30/2025 they have a big marketing deal, it has been in the paper for 2 or 3 weeks for people to come by and have something to eat. So, they opened up the dining room today. I think it was just for the convenience to have this event.”

In an interview with Collateral Contact 2 (CC2), Local Health Jurisdiction (LHJ) and Epidemiologist on 01/29/2025 at 1:54PM, CC2 stated, “We got notified by the facility on the 13th (01/13/2025). That was the only communication.” CC2 stated, “Over the past 1.5 weeks I have made several attempts to reach out to them which were unsuccessful.” CC2 expressed concerns with infection control practices in the facility and stated, “We got 3 separate calls [from the public] within the past few days. Two of them from the community, and one from an employee that wanted to remain anonymous. That raised a red flag. We reached out and got no response from them. The employee asked to remain anonymous, but they reported similar things [as the public], including [residents with] ongoing similar GI (Gastrointestinal) symptoms.” CC2 stated that the anonymous employee was told by facility management that it was norovirus, and that they expressed concerns for residents and staff. CC2 stated “this reiterated a pattern that they the staff, residents, and visitors were being told it was norovirus by leadership, but no new cases were reported to us.” CC2 stated that the anonymous employee stated that the facility had plans to “re-open everything.” CC2 stated that the anonymous staff member reported that they have seen residents with symptoms as recent as Monday 01/27/2025. CC2 stated, “We would like to clear them [to lift outbreak status], but we had not heard from them.” CC2 then stated that they have recently made contact with the facility on 01/29/2025. CC2 stated that Staff A, the Administrator, “finally replied that they did not have any residents with new symptoms for 5 days and they were opening everything up.” CC2 stated that they were not sure where Staff A got the “5-day information,” as this is not the recommendation of the LHJ. CC2 stated “the protocol is that they are supposed to speak with us about it. Staff A mentioned in the email that they didn’t know they had to tell us, but we did communicate that to them.”

During an onsite visit to the facility on 01/30/2025, at 10:00AM, observation showed there was no signage in place, regarding any outbreak in the facility. Upon entering the facility, no staff or residents were observed wearing any source control (surgical masks

or N95 masks).

During an interview with Staff A, on 01/30/2025 at 10:05AM, Staff A was asked to discuss the recent Gastral Intestinal (GI) communicable disease outbreak in the facility. Staff A stated, “I am not sure of when it exactly started, but we notified the state and the health department right away. It was like a norovirus.” Staff A stated that it was not officially confirmed as norovirus. Staff A then stated, “Yesterday (01/29/2025) was the first time we had heard anything form the health department [LHJ].” Staff A was asked if the facility was still currently in outbreak. Staff A stated that they lifted precautions yesterday (01/29/2025) because they have had no new, or symptomatic residents for 5 days. Staff A then stated, “Today is the 7th day of no new gastro symptoms. We are just doing what we normally do.” Staff A was asked where the guidance for 5 days of quarantine/isolation was obtained, and if this was a written facility policy. Staff A stated it was a verbal teaching they obtained while training for their position by the previous Administrator. Staff A was asked what preventions were put into place to mitigate the spread of illness. Staff A stated, “We sent out an email to families. We put a sign on both entrances. We put all the masks out. Staff were required to wear masks. We had masks out for visitors. We shut down dining and activities right away. It remained shut down until we thought we could remove it, the end of the timeline [5 days].” Staff A was asked where the PPE was kept for staff to use. Staff A stated, “We use a nightstand, with PPE inside.” Asked what type of PPE staff were expected to be worn when staff are entering a positive resident room. Staff A stated, “They are all fit tested. So, if they are working directly with residents, we followed it just like the flu and they would wear N95 masks.” “For meals we had all the food on meal trays, paper plates. Everything needed to be on paper for GI. We did do that. Everything was in the resident rooms. Garbage right inside the apartment. Hand hygiene in the rooms. We pressed the issue; if it is noro[virus], hand sanitizer does not necessarily kill it, so staff were to wash hands with soap and water. We did extra cleaning, handrails doorknobs to get rid for.” Staff A was asked what type of monitoring was done for positive residents. Staff A stated, “For positive residents. They are put on alert. When their symptoms start it goes into the charting notes, but it stated what their symptoms are, and staff are following them for how long they are sick, and staff write progress notes.” Staff A was asked the frequency the residents would be monitored, and notes would be completed by staff. Staff A stated that there should be a note every day [while the resident is symptomatic] if not more. Staff A was then asked to provide progress notes/alert charting for R1, from onset of symptoms to resolution of symptoms for department review. Review of provided progress notes for monitoring of R1 showed R1 was not monitored after becoming symptomatic, as no notes were written by staff.

During an interview with Staff A on 01/30/2025 at 1:03PM, Staff A was asked why there was no monitoring completed for R1. Staff A stated, “They [staff] should have done that.”

During an interview with Staff D, Medication Technician (Med Tech) on 01/30/2025 at 10:35AM, Staff D was asked if they were aware of the outbreak, and what the facility management told them the communicable disease was. Staff D stated, “I am not positive it if was ever confirmed, but we expected Norovirus.” Staff D was asked if the facility was still in outbreak. Staff D stated, “We are not in outbreak anymore.” Staff D

was asked what type of PPE they would wear while caring for a positive resident. Staff D stated, “Face masks, gown, gloves, and normally a face shield as well.” Staff D was asked where this PPE was kept. Staff D stated, “It was kept in drawers right in front of the rooms. It gets placed there when they start to have symptoms.” Staff D was asked to explain their process of exiting a resident room after completing care of a positive resident, while not yet having removed their PPE. Staff D stated, “Untie gown, put it in waste bin, then take off my face shield, I would leave my mask on, then take my gloves off. Then I take off my mask, toss gloves. and wash my hands.” Staff D was asked if they would wash their hands in the resident room before leaving. Staff D stated, “No, I wash my hands in the nearest sink after leaving the room.” Staff D was asked if all residents had soap in their rooms for them to utilize. Staff D stated that not all residents have soap in their rooms. Staff D stated that they were not sure the reasoning for not all residents having soap in their rooms. Staff D stated, “Sometimes some residents want the soap dispensers removed so they use bar soap.” Staff D was asked what they would do if after caring for a resident, they noticed their hands were visibly soiled. Staff D stated, “I am wearing gloves, so they wouldn’t be soiled.” Staff D was then asked if somehow body fluids or waste got onto their hands or wrist during care, what they would do. Staff D stated, “I would probably use my elbow to turn on the faucet and wash my hands in the room.” Staff D was then asked how they would do this if there was no soap in the room. Staff D stated, “I would use whatever the resident had in there. But if not, I would use my elbow to open door, exit and go wash again somewhere else.”

During an interview with Staff E, caregiver, on 01/30/2025 at 10:50AM, Staff E was asked if there have been any residents that still were experiencing GI symptoms. Staff E stated, “The only resident that I know is one that just went out [to the hospital].” Staff E was asked the name of the resident. Staff E stated, “[Resident 2[R2].” Staff E was asked to explain what happened with R2. Staff E stated, “They got sick this morning. I came in and I saw some vomit on their nightgown.” Staff E stated that they did not know how R2 was doing the day prior (01/29/2025), so they asked other caregivers to which they notified them that R2 was “feeling OK”. Staff E stated that this morning R2 seemed weaker than previous days. “They called EMS (Emergency Medical Services), and they did take [them] to the hospital.” Staff E was asked what type of PPE they would wear while caring for a positive resident. Staff E stated, “Gowns, gloves, masks, face shields.” Staff E was asked where these PPE supplies were kept. Staff E stated, “We usually set up a station outside of their room. we put stuff in there and put the PPE in there. We also put something on the door telling everyone they are sick.” Staff E was asked to explain her process of exiting a resident room after completing care of a positive resident, while not yet having removed their PPE. Staff E stated, “we get our gown off, face shield, gloves and put it in the garbage; the garbage can is in the room which is used specifically for PPE. I usually will use some hand sanitizer and leave the room.” Staff E was asked if all residents had soap in their rooms for them to utilize. Staff E stated, “Some [residents] have soap dispensers, and some do not. Not sure what that is about.” Staff E then stated that most of the time residents do have soap in their rooms, but they have encountered occasions when there was not. Staff E was then asked if somehow body fluids or waste got onto their hands or wrist during care, what they would do. Staff D was observed to hesitate for a moment before answering, “I don’t know.”

During an interview with Staff C, Housekeeping Director, on 01/30/2025 at 3:18PM, Staff C was asked if they knew if soap was provided in all resident rooms. Staff C stated, “I have not been in any of the rooms, but I request from my housekeepers to always make sure there is soap in the room.” Staff C then stated that the are uncertain of the reason, but they were told to take down the automatic soap dispensers when a resident discharges from the facility. Staff C then stated that they know have the supplies as they stated they order pump-bottle soap dispensers, and paper towels. Staff C was asked if they could say for certain if soap and paper towels were provided in all resident rooms. Staff B stated, “I cannot say 100% certainty that soap and paper towels are in all rooms, but I know we have it; the supplies are back in my office. That would be part of their housekeeping normal duties to replace/fill them.” Staff C was asked if there was any reason that soap and paper towels would not be provided in all resident bathrooms. Staff C stated, “There is no reason that there wouldn’t be.”

During an observation of resident room number [redacted], on 01/30/2025 at 1:27PM, a hand sanitizer dispenser was observed to be on the wall by the door leading into the hallway. In the resident bathroom, observed there to be a pump-bottle soap dispenser on the bathroom counter, but noted there was no automatic soap dispenser on the wall, and no paper towel dispenser for staff or residents to utilize.

During an observation of Resident 2 (R2)’s room, [redacted], on 01/30/2025 at 2:10PM, noted an automatic hand sanitizer dispenser on the wall outside of R2’s bathroom. Observed there to be a pump-bottle soap dispenser on the bathroom counter, but noted there was no automatic soap dispenser on the wall in the bathroom, and no paper towel dispenser in the bathroom for staff or residents to utilize.

During an observation of random resident room, [redacted], on 01/30/2025 at 2:14PM, observed that resident bathroom did have an automatic soap dispenser on the wall in bathroom, however observed that it was not operational.

During an observation of random resident room, [redacted], on 01/30/2025 at 2:16PM, observed that the resident bathroom did not have an automatic soap dispenser on the wall, and no paper towel dispenser in the bathroom for staff or residents to utilize.

During an interview with Staff A, on 01/30/2025 at 4:23PM, Staff A was notified of concerns with handwashing procedures which included responses from staff and supplies not being made readily available for staff to utilize after providing resident care. Staff A was asked if there was any reason for soap and paper towels to not be provided in every resident room. Staff A stated, “There should be at least a soap dispenser, like a little pump one in every room.” Staff A was then asked about the lack of paper towels. Staff A then stated that they agreed that soap and paper towels need to be in place for the caregivers to utilize after care. Staff A was asked if they agreed that handwashing should be done by staff in the resident room, prior to leave the resident room. Staff A stated, “Yes.”

Statement of Deficiencies	License # 2652	Compliance Determination # 53964
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 8 of 8	Licensee: CREF3 Oxford Living Sherwood LLC	02/10/2025

During a follow-up interview with CC2, on 02/10/2025 at 3:19PM, CC2 was notified of the breaks in infection control practices in the facility that were observed by the department on 01/30/2025. CC2 was asked to comment on any concerns they had regarding the facility response to the outbreaks. CC2 stated, "This facility had a recent influenza outbreak where their communication was also poor, and their reporting was lacking. The continuous disease spread is indicative of a scenario where disease spread likely could have been prevented. When I examine the pattern of spread based on the line list (a list of positive residents to help establish a pattern), it reflects the hand hygiene issues [that were] reported - particularly the fact that there were several waves of illness. With a norovirus outbreak that is properly handled, there is typically one large wave initially (by the time someone is vomiting, it's usually too late to prevent some spread initially) but then that dies off quickly. However, because fomite transmission is very possible with norovirus, it makes me suspect issues with perhaps surfaces that were not getting cleaned appropriately as well as hands!"

This is a recurring citation previously cited on 10/22/2024.

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) 03/12/2025

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

Administrator, Administrator
Administrator (or Representative)

02/27/2025
Date

During a follow-up interview with CC2, on 02/10/2025 at 3:19PM, CC2 was notified of the breaks in infection control practices in the facility that were observed by the department on 01/30/2025. CC2 was asked to comment on any concerns they had regarding the facility response to the outbreaks. CC2 stated, “This facility had a recent influenza outbreak where their communication was also poor, and their reporting was lacking. The continuous disease spread is indicative of a scenario where disease spread likely could have been prevented. When I examine the pattern of spread based on the line list (a list of positive residents to help establish a pattern), it reflects the hand hygiene issues [that were] reported - particularly the fact that there were several waves of illness. With a norovirus outbreak that is properly handled, there is typically one large wave initially (by the time someone is vomiting, it's usually too late to prevent some spread initially) but then that dies off quickly. However, because fomite transmission is very possible with norovirus, it makes me suspect issues with perhaps surfaces that were not getting cleaned appropriately as well as hands!”

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

_____ _____

Administrator (or Representative) Date