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

02/25/2025

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) 55377 (Completion Date 02/25/2025) and 41519 (Completion Date 07/03/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/25/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

The Department staff who did the On Site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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: 130110
Compliance Determination #: 41519
Region/Unit #: RCS Region 3 / Unit E
Investigator: Maria Salas
Investigation Date(s): 05/15/2024 through 07/03/2024
Complainant Contact Date(s):

Allegation(s):
Facility report of fall with injury and death.

Investigation Methods:

Sample:	Total residents: 71 Resident sample size: 3 Closed records sample size: 2
Observations:	Residents Activities Dining Staff to resident interactions Resident rooms Resident to resident interactions
Interviews:	Identified staff Nursing staff Residents Family members
Record Reviews:	Medical records State reporting log Incident investigation Facility policies

Investigation Summary:
Based on record review and interview the facility failed to monitor resident's well-being and implement safety interventions as needed. Failed practice identified.

Conclusion / Action:

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

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AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

Statement of Deficiencies	License #: 2652	Compliance Determination # 41519
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 1 of 4	Licensee: CREF3 Oxford Living Sherwood LLC	07/03/2024

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 05/15/2024 and 07/03/2024 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 127695, 129719, 130110

The following sample was selected for review during the unannounced on-site visit: 3 of 71 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Maria Salas, ALF 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

07/09/2024
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: 7-10-24

WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:

(3) Evaluate, in order to determine if there is a need for further action:

(a) The changes identified in the resident per subsection (2) of this section; and

(b) Each resident when an accident or incident that is likely to adversely affect the resident's well-being, is observed by or reported to staff persons.

(4) Take appropriate action in response to each resident's changing needs.

This requirement was not met as evidenced by:

Based on record review and interview, the facility failed to evaluate and implement safety interventions for 1of 3 (Resident 1) residents reviewed. This failure placed the resident at risk of repeated harm and injury from falls, and decreased quality of life.

Findings included...
Record review of Resident 1's (R1) Face Sheet, showed R1 admitted on [redacted]2023 with a history of stroke (a blockage in or burst to a vessel supplying blood flow to the brain), hypertension (when the pressure in your blood vessels is too high), atrial fibrillation (an irregular, often fast heartbeat), thoracic fracture (break to the bones in the mid back) noted on 04/26/2024.

Record review of R1's Negotiated Service Plan/ Change in Condition Reassessment, dated 05/03/2024, showed that R1 was placed on hospice care. R1 had no memory impairments. R1 required moderate hands-on staff assistance for mobility. R1 required total staff assistance for transfers. R1 was a potential fall risk and had no staff interventions for fall prevention listed. R1 was a total assist with toileting three times per day. R1 was independent with and did not require assistance with using the community response system.

Record review of a Fall Report for R1, dated 05/03/2024 at 3:30am, showed nursing staff documented that call light was answered by care staff and R1 was found lying on the floor in the bathroom doorway. Bleeding was noted by staff to the back of R1's head area. R1 refused to be transported to local hospital for further evaluation. No new staff interventions for resident safety documented as initiated after this fall occurrence.

Record review of R1's Progress Note, dated 05/04/2024 at 8:15am, showed staff documented R1 returned to facility from hospital with poor safety awareness and need for increased level of care due to requiring assistance with mobility. Staff documented R1 did

not know how to call or ask for help when needed.

Record review of a Fall Report for R1, dated 05/04/2024 at 11:30am, showed staff documented R1 sustained an unwitnessed fall and was found on the floor by the bed. R1 was able to state that causation was due to R1's foot not working when attempting to walk on her own, resulting in her slipping and falling. No new staff interventions for R1's safety and increased fall potential documented was initiated after this occurrence.

Record review of a Fall Report for R1, dated 05/06/2024 at 1:00am, showed staff documented R1 was found on the floor with blood noted on hands, legs and forehead areas. R1 was able to state that she had attempting to get up from bed and had fallen. Staff noted two lacerations to forehead area. EMT (Emergency Medical Technician) was called for further assessment. Staff documented after EMT assessment it was decided by EMT not to transport resident for further evaluation. Hospice was notified. No new staff interventions for resident safety documented as initiated after this fall occurrence.

Record review of a Fall Report for R1, dated 05/06/2024 at 5:00am, showed staff documented R1 was found on the floor in room. R1 stated that she had been trying to get up from the bed and fell. Every 15-minute checks and one-to-one observation intervention initiated after this fall occurrence.

Record review of R1's Progress Note, dated 05/06/2024 at 1:00pm, showed staff documented resident had a change in condition and was noted to be vomiting large amounts of coffee ground looking substance. Hospice was notified and assessed resident. Resident noted to be actively dying.

Record review of R1's Progress Note, dated [redacted]2024, showed R1 was pronounced deceased at 5:55am on [redacted]2024.

In an interview on 07/03/2024 at 12:07pm, Staff A, Registered Nurse, stated that her role with the company was to follow up on all occurrence/fall reports and make sure all sections of the report were properly completed. Staff A stated that she rules out any abuse and/or neglect. Staff A stated that administration was responsible for implementing safety interventions as needed after an occurrence or fall had happened.

In an interview on 05/15/2024 at 12:58pm, Staff B, Administrator, stated that after the fall on 05/03/2024 at 3:30am the staff had called R1's son to come in and sit with R1 until she had fallen asleep. Staff B stated that R1's son was at R1's bedside for a couple of hours and then needed to leave for work. Staff B stated no other interventions had been put in place to ensure R1's safety. Staff B stated that no other interventions had been put in place on 05/03/2024 for resident safety after R1's fall. Staff B stated that no interventions had been put in place after R1's fall on 05/04/2024. Staff B stated no interventions had been put in place for resident safety after R1's first fall on 05/06/2024. Staff B stated that R1 had been placed on a one-to-one observation after the second fall on 05/06/2024. On 07/03/2024 Staff B stated that she was the person responsible for implementing safety interventions

after falls and occurrences. Staff B stated that she had failed to implement safety interventions on 05/03/2024, 05/04/2024 and the first fall that occurred on 05/06/2024 at 1:00am.

In an interview on 07/03/2024 at 1:02pm with former Staff C, Medication Technician (MT), stated that it was the role of the MT on duty to initiate the fall report, to identify causation if able, notify all required persons, perform first aid if needed, and notify EMS if necessary. Staff C stated that safety intervention were determined by administration.

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) August 15th, 2024

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

Administrator (or Representative) — Date: 7-10-24