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) 55376 (Completion Date 02/25/2025) and 41903 (Completion Date 07/23/2024).

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-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special 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: 132351
Compliance Determination #: 41903
Region/Unit #: RCS Region 3 / Unit E
Investigator: Maria Salas
Investigation Date(s): 05/28/2024 through 07/23/2024
Complainant Contact Date(s):

Allegation(s):
Allegation of monitoring of change in condition of residents not being performed.

Investigation Methods:

Sample:	Total residents: 72 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents Activities Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	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 follow the facility's Alert Charting policy to monitor and document resident's changes in condition to ensure resident safety. 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 05/28/2024 and 07/12/2024 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 130869, 132351

The following sample was selected for review during the unannounced on-site visit: 3 of 72 current residents and 1 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

07/30/2024
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: 8/4/24

WAC 388-78A-2600 Policies and procedures.

(1) The assisted living facility must develop and implement policies and procedures in support of services that are provided and are necessary to:

(a) Maintain or enhance the quality of life for residents including resident decision-making rights;

(b) Provide the necessary care and services for residents, including those with special needs;

This requirement was not met as evidenced by:

Based on record review and interview the facility failed to implement their Alert Charting Policy for 1 of 3 (Resident 1) residents after a change in condition. This failure placed the resident at risk of unidentified care needs, and decreased quality of life.

Findings included...

Record review of the facility's Alert Charting Policy, dated 03/17/2018, showed staff were to initiate alert charting using the Alert Charting form if a resident was experiencing an adverse change in his or her health condition that needed to be communicated to other team members of the resident care team. Examples of circumstances given that would trigger initiation of alert charting included but was not limited to behavior changes. The policy stated that the alert charting form should have been placed in the Alert charting binder located at the nurse's station, indicating the concern, and should have served as a trigger requiring the licensed nurse to document a follow-up note related to specified concerns.

Record review of the facility's Alert Charting form, dated 03/17/2018, showed reasons for alert charting to include but not limited to any changes of condition that would have required monitoring.

Record review of Resident 1's (R1) Face Sheet, showed R1 admitted on [redacted]2024 with a history of dementia (a loss of cognitive function thinking, remembering, and reasoning).

Record review of Alert Binder in the Memory Care Unit, dated 04/01/2024 through 05/28/2024, showed R1 had not been placed on alert monitoring during this time frame for change in condition.

In an interview on 05/29/2024 at 10:00am, Staff A, Caregiver, stated that they had seen R1 acting abnormally and not at R1's normal responsive state when Staff A went to get R1 out of bed and ready for breakfast. Staff A state that R1 appeared ill. Staff 1 stated that the change in condition had been reported to Staff B, Licensed Practical Nurse (LPN) on duty. Staff A stated that the LPN assessed R1. Staff A stated that after the Staff B's assessment, Staff B voiced to Staff A that R1 had not been feeling well for multiple days. Staff 1 stated that nothing was done at that time and no instructions were given for care. Staff A stated that later in the morning R1's husband had come to visit as he did every day. Staff 1 stated that R1's husband voiced he was concerned about R1 and that she had been feeling ill for multiple days. Staff A stated that she encouraged R1's husband to request Staff B to have R1 transported to the local hospital for further evaluation. Staff A stated that R1's husband had gone and requested Staff B to have R1 transported to the local hospital for evaluation.

In an interview on 07/10/2024 at 12:32pm Staff B stated that he works Friday through Monday every week, dayshift. Staff B stated that R1 "must have been fine" on Friday (05/24/2024) and Saturday (05/25/2024) otherwise Staff B would have sent R1 out to the local hospital for evaluation. Staff B stated that he had assessed R1 on the morning of [redacted]2024 after the caregiver reported a change in condition with R1. Staff B stated that he had not taken any vitals as part of his assessment. Staff B stated that after breakfast R1's husband had come to visit and requested Staff 2 to call the medics to have R1 sent out to the local hospital for evaluation due to him being concerned with how his wife looked. Staff B stated that he was unable to recall the condition R1 was in at the time of his assessment and stated that he would need to review his documentation. Staff B stated that when R1's husband had come and requested for emergency medical services to be called, he had notified R1's husband that the medics would be able to complete a better assessment because all he had was his stethoscope and his skills, but that the medics would be able to perform cardiac monitoring. Staff B stated that he did not take a blood pressure because all they have at the facility was a wrist cuff blood pressure and that those were notoriously wrong.

Record review of R1's Observation Notes, dated 04/26/2024 through 05/28/2024, showed a late entry had been written on 05/28/2024 for an event that occurred on 05/24/2024. Entry stated that R1 had vomiting and diarrhea. R1 had not been placed on alert monitoring after this occurrence. On [redacted]2024 at 10:45 pm, evening shift staff documented that R1 had been sent out to the local hospital at 11:45am on [redacted]2024 with a temperature of 101 degrees Fahrenheit via emergency medical services. A late entry was entered for [redacted]2024 that the local hospital had been called at 11:33pm to obtain an update on R1's status, staff notified that R1 had been admitted related to sepsis (a system wide infection in the blood stream). On [redacted]2024 at 02:45pm it was documented by staff that R1's husband had called the facility at 10:00am and informed them that R1 had passed away. On [redacted]2024 at 06:45am. No documentation of alert monitoring documented by Staff B from change in condition found on [redacted]2024.

In an interview on 05/29/2024 at 1:35pm, Staff C, Executive Director, was asked per the Alert Charting policy should R1 have been placed on alert monitoring on 05/24/2024 after having vomiting and diarrhea? Staff C stated that yes, under the circumstances noted in the observation notes, R1 should have been placed on alert monitoring and vitals should have been taken daily to monitor R1's condition.

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) ~~9/12/24~~ 9/6/24.

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

JBoschke
Administrator (or Representative)

8-4-24
Date