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

01/13/2025

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) 53136 (Completion Date 01/13/2025) and 47202 (Completion Date 10/10/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/13/2025 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:

(a) Develop and implement a system to identify and manage infections;

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

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2652
Intake ID: 143154
Compliance Determination #: 47202
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 09/16/2024 through 10/10/2024
Complainant Contact Date(s):

Allegation(s):
Quality of Care/treatment: Report of a medication error.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 4 Closed records sample size: 2
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Facility policies Personnel files Staff training records Care Plan Progress Notes Nurse Delegation Documentation Staff List Characteristic Roster

Investigation Summary:
Facility followed procedure by notifying appropriate parties and monitoring resident after the medication error. No failed practice identified.
Facility failed to ensure staff member had adequate training prior to administering insulin to resident. Failed practice identified.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2652
Intake ID: 143667
Compliance Determination #: 47202
Region/Unit #: RCS Region 3 / Unit E
Investigator: Pamela Horlick
Investigation Date(s): 09/16/2024 through 10/10/2024
Complainant Contact Date(s):

Allegation(s):
Infection Control: Report of a covid-19 outbreak in the community.

Investigation Methods:

Sample:	Total residents: 77 Resident sample size: 4 Closed records sample size: 2
Observations:	Identified resident Residents Dining Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	State reporting log Incident investigation Facility policies Personnel files Staff training records Care Plan Progress Notes Nurse Delegation Documentation Staff List Characteristic Roster

Investigation Summary:
Facility failed to ensure staff had proper fit testing done to ensure safety while providing care wearing an N95. 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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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 09/16/2024 and 10/14/2024 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 143154, 143667

The following sample was selected for review during the unannounced on-site visit: 4 of 77 current residents and 2 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

10/22/2024
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) — 10/25/2024 Date

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:

(a) Develop and implement a system to identify and manage infections;

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

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices were implemented for 1 of 1 facility reviewed. This failure placed 77 of 77 residents and 83 staff at risk of a spread of an infectious disease.

Findings included...

WAC 296-842-14005 "Provide medical evaluations.
Medical Evaluation Process
Step 1: Identify employees who need medical evaluations AND determine the frequency of evaluations from Table 7. Include employees who:
(a) Are required to use respirators [a device worn over the mouth and nose or entire face that prevents inhalation of dust, smoke, and other substances]; or
Step 6: Obtain a written recommendation from the LHCP that contains only the following medical information:
(a) Whether or not the employee is medically able to use the respirator;
(b) Any limitations of respirator use for the employee;
(c) What future medical evaluations, if any, are needed;
(d) A statement that the employee has been provided a copy of the written recommendation"

WAC 296-842-15005
"Conduct fit testing.
(1) Provide, at no cost to the employee, fit tests for ALL tight fitting respirators on the following schedule:
(a) Before employees are assigned duties that may require the use of respirators;
(b) At least every twelve months after initial testing;"

WAC 296-842-12010
"Keep respirator program records
(1) A written copy of the current respirator program must be kept by the employer.
(2) Keep each employee's current fit test record, if fit testing is conducted, until the next fit test is administered. Fit test records must include:
(a) Employee name;
(b) Test date;
(c) Type of fit-test performed;
(d) Description (type, manufacturer, model, style, and size) of the respirator tested;
(e) Results of fit tests, for example, for quantitative fit tests include the overall fit factor AND a print out, or other recording of the test.
(3) Keep training records that include employees' names and the dates trained.
(4) Keep written recommendations from the LHCP.
Reference: See chapter 296-802 WAC, Employee medical and exposure records, for additional requirements that apply to medical records.
(5) You must allow affected employees and their representatives to examine and copy records required by this section."

Review of United States Environmental Protection Agency website, dated 08/27/2024, showed under section "Indoor Air and Coronavirus (Covid-19 [a respiratory illness]), that "Spread of COVID-19 occurs via airborne particles and droplets. People who are infected with COVID can release particles and droplets of respiratory fluids that contain SARS CoV-2 virus [Covid-19] into the air when they exhale (e.g., quiet breathing, speaking, singing, exercise, coughing, sneezing). The droplets or aerosol particles vary across a wide range of sizes-from visible to microscopic. Once infectious droplets and particles are exhaled, they move outward from the person (the source). These droplets carry the virus and transmit infection. Indoors, the very fine droplets and particles will continue to spread through the air in the room or space and can accumulate."

Review of Centers for Disease Control (CDC) website, titled, "Transmission-Based Precautions," dated 04/03/2024, showed, "Use airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route...Use personal protective equipment (PPE) appropriately, including a fit-tested NIOSH-approved N95 or higher level respirator for healthcare personnel."

Record review of facility policy titled, "Covid Testing Policy and Work restrictions for HCP [Health Care Providers]," revised 05/06/22, showed, "A robust testing program can identify cases earlier, allowing early isolation, identification of people exposed and early quarantine when indicated."
Record review of facility policy, titled, "COVID Policy of Personal Protective Equipment/Masking for HCP" dated 05/06/2022, under section titled, "Improving the Fit of Masks in Healthcare Setting," showed, "The fit of the device used to cover the

wearer's mouth and nose is a critical factor in the level of source control (preventing exposure of others) and the level of the wearer's exposure to infectious particles. Fit-tested respirators offer the highest level of both source control and protection against inhalation of infectious particles in the air. Facemasks that conform to the wearer's face so that more air moves through the material of the facemask rather than through gaps at the edges are more effective for source control than facemasks with gaps and can also reduce the wearers exposure to particles in the air. Improving how a facemask fits can increase the facemasks effectiveness for decreasing particles emitted from the wearer and to which the wearer is exposed...N-95 mask will be worn with any area or resident that has been identified positive COVID or suspected COVID...All staff that wear a N-95 mask will be fit tested prior to wearing NIOSH-approved N-95 masks and a record of proper fitting mask will be kept for reference and maintained by the nursing staff...Medical clearance will be provided prior to fit testing...Fit testing will occur yearly or with any major changes to the face such as weight gain/loss."

In an interview on 09/16/2024 at 9:21 AM, Collateral Contact 1, Public Health Nurse, stated they were getting reports from community members that staff at the facility were not doing source control [wearing PPE]. CC1 stated that staff at the facility should be wearing a well fitted face mask or an N-95 while in the halls, but when staff were providing care to residents they should be wearing an N-95 mask, eye protection, gown and gloves. CC1 stated the facility told them that staff weren't fit tested. CC1 was asked when the facility would be out of outbreak status, they stated the soonest possible date would be 09/25/2024.

In an observation on 09/16/2024 at 10:55 AM, Staff D, Receptionist, was sitting at the reception desk accessible to residents and was not wearing a well fitted face mask or an N-95.

In an interview on 09/16/2024 at 10:58AM, Staff A, Executive Director, stated they aren't doing well with fit testing. Staff A was asked how often staff should be fit tested, they stated annually and upon hire. Staff A was asked if they had been in touch with the local health jurisdiction (LHJ) for guidance, they stated they had been in touch with them. Staff A was asked when outbreak status will be lifted, they stated once they get all negatives it will be two weeks from the last negative. Staff A was asked what the LHJ instructed them to do about staff wearing masks, they stated that facility staff should be wearing masks until the outbreak was lifted. Staff A was asked if that includes all staff throughout the building, they stated yes.

Records request on 09/16/2024 at 11:14 AM, Staff B, Marketing, was asked to provide the facility fit testing records for staff.

In a joint interview on 09/16/2024 at 11:28 AM, Staff B stated they didn't know where the fit testing records were. Staff A was asked if all the staff are fit tested, they stated, no, not all of them, but they haven't been done since covid first started. We are working on getting them all fit tested.

In an interview on 09/16/2024 at 11:57 AM Staff E, Medication Technician, was asked what PPE they were required to wear when entering COVID positive resident rooms, they stated they would wear an N95 mask, gown, gloves, and a face shield. Staff E was asked if they were fit tested for an N95, they stated yes they were fit tested when covid first started four years ago.

In an interview on 09/16/2024 at 12:11 PM, Staff A, Executive Director was asked if the facility could provide fit testing records, they stated, not everyone was fit tested. Staff A was asked what they do for medical clearances, they stated, they had no idea and would figure it out and get an answer.

In an interview on 09/16/2024 at 12:20 PM, Staff F, Medication Technician, was asked if they had been fit tested to wear an N95, they stated, they had been. Staff F was asked when they were fit tested, they stated at their last place of employment a few years ago. Staff F was asked if they had been fit tested from their current employer, they stated, no.

In an interview on 09/16/2024 at 12:39 PM, Staff G, Medication Technician, was asked what PPE they were required wear when entering a covid positive resident room, they stated an N95 respirator, gown, gloves and a face shield. Staff G was asked if they are fit tested, they stated no, they didn't know they had to be fit tested for N95's there at the facility.

In an interview on 09/16/2024 at 1:12 PM, Staff C, Director of Nursing, was asked if they were fit tested for an N95, they stated they were at their previous employment. Staff C was asked if they had fit test results for their current employment at the facility, they stated, no they didn't know they needed them at the current facility. Staff C was asked if there was a process for medical clearances, they stated they didn't know. Staff C was asked if they were aware of fit testing requirements, they stated, no they were not aware.

In an interview on 09/16/2024 at 1:53 PM, Staff H, Caregiver, was asked if they were fit tested for an N95, they stated they were, but that it was a couple of years ago.

In an observation on 09/16/2024 at 2:07PM, Staff I, Caregiver, was observed coming out of a resident's room without an N95 mask or a surgical mask on. They were asked what they wear when they are providing care to a covid positive resident, they stated they put on a N95, gown and gloves.

In an observation and interview on 09/16/2024 at 2:17 PM, Staff J, Caregiver, was observed walking in the hallway with no N95 or surgical mask on their face. Staff J was asked if they were fit tested, they stated no, they had not been fit tested. Staff J was asked if they remembered being medically cleared to be fit tested, they stated no. Staff J was asked if they wear an N95 mask while performing care on covid positive residents, they stated no, they were informed the surgical mask was all they needed. Staff J was

asked what else they wore while providing care, they stated gloves and a gown. Staff j was asked if they wear anything else, they stated nope.

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) 11/23/2024 .

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

Administrator 10/25/2024
Administrator (or Representative) Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

This requirement was not met as evidenced by:

Based on interview and record review the facility failed to ensure staff were trained to provide the necessary care and services for 1 of 2 residents (Resident 1 [R1]). This failure resulted in R1 receiving the wrong medication and placed the resident at risk for medical complications for not receiving medications as prescribed.

Findings included...

Record review of R1's face sheet, dated 09/16/2024, showed that R1 was admitted to the facility on [redacted]/2021. R1 had a medical diagnosis of [redacted].

Review of Department Records showed that a report was made by the facility on 08/16/2024 notifying the Department that on 08/15/2024 at 11:00 AM R1 received 23 units of Insulin Glargine prior to lunch instead of receiving 23 units of the scheduled Insulin Aspart. Staff K, Med Technician, noticed Staff L, medication technician, had the wrong colored insulin pen after the insulin had been administered.

Record review of R1's observation note entry by Staff K, Medication Technician, showed on 08/15/2024 Staff K noted that the wrong insulin was given to R1.

In an interview on 09/18/2024 at 2:07 PM, Staff L stated Staff L was asked by Staff K to give R1 the insulin. Staff L took the insulin pen. Staff L was asked if Staff K was with them while they administered the medication. Staff L stated no. Staff L stated they came back to the medication room where Staff K saw the insulin pen in their hand and asked, "you didn't give that one, did you? Staff L stated they did. Staff L stated that they faxed the doctor and informed their superiors of the medication error. Staff L was asked if any additional education was done, they stated yes. They talked to Staff A and Staff B about the process of medication administration. Staff L stated the facility doesn't really have a physical training program. Staff L stated that Staff B stated they were going to send me something saying I was educated on it. Staff L stated they don't feel as if they were educated on it. Staff L was asked if they felt like they got enough hands on training, they stated, no they didn't teach them how to use the pen. Staff L stated the facility definitely could give further training. Staff L stated they felt its common there to not train thoroughly.

In an interview on 09/25/2024 at 1:11 PM, Staff C, Director of Nursing, was asked to explain the process for when a medication technician was to be nurse delegated, they stated the nurse delegator would teach a class and give a test to the prospective med tech, after they pass their test, then they will have additional training at the facility and a skill check off. Staff C stated they will shadow another med tech for hands on training. Staff C was asked how long does someone shadow for, they stated five days of shadowing. Staff C was asked if Staff L was checked off, they stated, they weren't checked off completely. Staff C stated the med tech would shadow the new med tech then they will both sign that they went over the procedure and was educated on it. Staff C was asked if they had documentation for Staff L that they were signed off, they stated, no they don't.

In an interview on 10/08/2024 at 10:01 AM, Staff A, was asked what additional training was done by the facility to train med techs on administration of insulin, they stated the nurse keeps up the training. Staff A stated they train them and will give them 5 days of training and if they need more then they can have more training. Staff A was asked if the med tech in training can give insulin by themselves during training, they stated the med tech in training would have someone following them. Staff A was asked if there was a facility policy related to the training that they explained, they stated, there was not.

The facility was not able to provide any documentation of Staff L's additional training to provide nurse delegated tasks to residents.

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) 11/23/2024 .

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

Administrator (or Representative) — Date: 10/25/2024