STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

04/14/2026

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) 75907 (Completion Date 04/14/2026) and 72791 (Completion Date 02/26/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/14/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

The Department staff who did the On Site verification:
Phan Pham, Complaint Investigator

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

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Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2652
Intake ID: 210756
Compliance Determination #: 72791
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 02/09/2026 through 02/26/2026
Complainant Contact Date(s):

Allegation(s):
Transfer and discharge - Named resident was transferred to memory care unit and the resident did not agree.

Investigation Methods:

Sample:	Total residents: 66 Resident sample size: 3 Closed records sample size: 1
Observations:	Named resident, residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Named residents, residents, staff members, administrative and member not associated with the facility.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to transfer and discharge, quality of care and treatments were reviewed. The assisted living facility failed to ensure staff members followed the transfer requirements in accordance with the Long-term care resident rights. Additional residents reviewed for care, services and safety had no concerns.

Conclusion / Action:

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

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Statement of Deficiencies	License #: 2652	Compliance Determination # 72791
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 1 of 5	Licensee: CREF3 Oxford Living Sherwood LLC	02/26/2026

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 02/09/2026, 02/10/2026 and 02/26/2026 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 210756, 211334, 211465, 212152

The following sample was selected for review during the unannounced on-site visit: 3 of 66 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Complaint Investigator
Clinton Fridley, Community Nurse Field Manager

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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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.

Clinton Fridley RN
Residential Care Services

03/11/2026
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)

03/12/2026
Date

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to allow a resident to exercise their right to participate in planning care, to direct their own service plan and to refuse any service by moving the resident into the locked memory care unit of the facility for 1 of 4 sampled residents (Resident 1). This failure resulted in Resident 1 feeling distressed and prevented the resident from participating proactively in care decision and placed the resident at risk of not being involved in care decision and a decreased quality of life.

Findings included...

RCW 70.129.140 Quality of life—Rights.
(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.
(2) Within reasonable facility rules designed to protect the rights and quality of life of residents, the resident has the right to: (e) Unless adjudged incompetent or otherwise found to be legally incapacitated, participate in planning care and treatment or changes in care and treatment; (f) Unless adjudged incompetent or otherwise found to be legally incapacitated, to direct his or her own service plan and changes in the service plan, and to refuse any particular service so long as such refusal is documented in the record of the resident.

Record review of facility policy titled "Resident Decisional Capacity & Guardianship,"

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revised 02/23/2018, documented that residents are presumed to have decision making capacity unless a court of law has deemed them to be incapacitated or the resident meets criteria specified by the resident in a legal document, such as a Durable Power of Attorney (DPOA). Residents will be involved in the informed consent process to the extent possible, even when the facility has determined the resident lacks the necessary capacity to make health care decisions.

Record review of facility resident records for Resident 1, showed the facility admitted the resident on [redacted]2024 with diagnoses including [redacted] and [redacted]. The resident was able to communicate their needs and had a colostomy (an opening in the colon that lets stools pass from the body without going through the anus). The records show that the resident had a financial Power of Attorney (POA) and Healthcare POA. The resident was transferred to the memory care locked unit on 01/09/2026.

Record review of document titled, "Medical Power of Attorney," dated 12/23/2025, showed that Resident 1 had appointed a friend to act as their medical power of attorney and shall "have the authority to make any and all medical decision on my behalf in the event I am unable to do so."

Review of Resident 1's assessment dated 01/15/2026, showed the resident was oriented to person, place, situation, and time. Resident 1 did not resist care and made appropriate decisions. Resident 1 did not have current or history of disruptive behavior, anxiety and depression. Resident 1 was independent with activities of daily living and had demonstrated how to activate emergency call system.

Review of Resident 1's NSP dated 01/16/2026 documented the resident had mild to moderate memory and orientation impairment, effectively communicate needs and required assistance with medication services. The resident was independent with transfers, ambulation, bathing, grooming, dressing, toileting (managing their colostomy bag), eating, and activities.

Observation on 02/09/2026 revealed the Assisted Living Facility had an assisted living section and a locked memory care unit. At 3:10 PM, Resident 1 was observed in the memory care unit ambulating in the hallway and then to their room. The resident was neatly groomed and dressed.

Review of Resident 1's progress notes on 01/01/2026, staff documented Resident 1 was seen at the hospital on [redacted]2025 for possible seizure like activity and loss of consciousness. Resident 1 was up and about per their routine and had been at baseline.

Review of Resident 1's progress notes dated from 01/02/2026 to 01/08/2026, documented Resident 1 had no acute complaints, walking in the facility frequently, complied with medication services, and had a non-injury fall on 01/06/2026.

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Review of Resident 1's progress notes on 01/09/2026 at 5:45 AM, staff documented Resident 1 was sleeping and in no acute distress. At 10:00 AM staff documented Resident 1 was moved to the memory care unit. At 12:45 PM, staff documented Resident 1 was not a happy camper. Resident 1 sat by the door, waited for a chance to "escape". Resident 1 told people that staff tricked and kidnapped the resident.

Review of Resident 1's progress notes on 01/10/2026 at 10:45 AM, documented Resident 1 was upset and distrustful of staff for moving the resident to the memory care unit.

In an interview on 02/09/2026 at 3:10 PM, Resident 1 stated staff members "dragged" them into the memory care unit and "locked them up against their will." Resident 1 stated that staff did not talk to them about moving to the memory care unit and that they would not have agreed. Resident 1 stated they were in a locked unit and could not go anywhere. Resident 1 stated that they were independent with their activities of daily living and care needs had not changed. Resident 1 stated they did not want to be in the memory care unit and had informed staff members of their preferences.

In an interview on 02/09/2026 at 4:16 PM, Staff E, Licensed Nurse, stated Resident 1 was very independent and "likes to be in control." Resident 1's level of care had not changed since they moved from the assisted living side of the building. Resident 1 needed assistance with medication administration and did not have any behavioral and/or safety issues.

In an interview on 02/10/2026 at 10:45 AM, Staff C, Medication Tech, stated Resident 1 was independent with care and managed their own colostomy bag. Staff C stated that Resident 1 was alert, angry, and had told every staff member that they did not want to be in the memory care unit. Staff C stated Resident 1 only needed assistance with medication services.

In an interview on 02/10/2026 at 10:51 AM, Staff D, Caregiver, stated Resident 1 was independent with their activities of daily living and took good care of their colostomy bag. Staff C said Resident 1 had told staff members on multiple occasions that they felt trapped and did not want to be in the memory care unit.

In an interview on 02/10/2026 at 11:00 AM, Staff A, Executive Director, and Staff B, Resident Care Coordinator, stated Resident 1 memory was declining, required higher level of care and more oversight. Staff A and Staff B stated Resident 1 was moved to the memory care unit due to a recommendation from the behavioral health provider. Staff A and Staff B stated that they had verbally communicated with Resident 1 and the resident's representatives regarding moving to memory care unit in December 2025. Staff A and Staff B stated that they have heard from Resident 1 regarding not wanting to be in the memory care unit.

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On 02/26/2026 at 2:46 PM, Resident 1 was observed in a room outside the locked memory care unit and stated that they were satisfied with being out of the memory care.

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) 04/10/2026.

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

[signature], Administrator — 03/12/2026

Administrator (or Representative) — Date

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