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

CREF3 Oxford Living Sherwood LLC
Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

RE: Sherwood Assisted Living License # 2652

Dear Administrator:

This letter addresses Compliance Determination(s) 79140 (Completion Date 06/16/2026) and 76336 (Completion Date 04/28/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 06/16/2026 and found no deficiencies. Your facility meets the Assisted Living Facility licensing requirements.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2703

The Department staff who did the on-site verification:
Phan Pham, Complaint Investigator

If you have any questions, please contact me at (253)442-3013.

Sincerely,

Laurie Anderson

Laurie Anderson, Community Field Manager
Region 3, Unit E
Residential Care Services

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

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

License/Cert.#: 2652
Intake ID: 219924
Compliance Determination #: 76336
Region/Unit #: RCS Region 3 / Unit E
Investigator: Phan Pham
Investigation Date(s): 04/22/2026 through 04/28/2026
Complainant Contact Date(s):

Allegation(s):
Neglect - Named resident was found on the floor with injuries to head.

Investigation Methods:

Sample:	Total residents: 65 Resident sample size: 3 Closed records sample size: 1
Observations:	Residents, environment, staff interactions with residents, staff members providing care and services, and safety measures.
Interviews:	Residents and interdisciplinary team members.
Record Reviews:	Sampled residents and incident reports.

Investigation Summary:
An on-site investigation was conducted, and the concerns related to resident neglect, quality of care and treatments were reviewed. The assisted living facility failed to ensure staff members positioned the resident's bed to a safe height. 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 # 76336
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 1 of 4	Licensee: CREF3 Oxford Living Sherwood LLC	04/28/2026

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 04/28/2026 and 04/22/2026 of:

Sherwood Assisted Living
550 W HENDRICKSON RD
SEQUIM, WA 98382

This document references the following complaint number(s): 219924, 219315, 221099

The following sample was selected for review during the unannounced on-site visit: 3 of 65 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Phan Pham, Complaint Investigator

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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Statement of Deficiencies	License #: 2652	Compliance Determination # 76336
Plan of Correction	Sherwood Assisted Living	Completion Date
Page 2 of 4	Licensee: CREF3 Oxford Living Sherwood LLC	04/28/2026

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

05/01/2026
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 (or Representative)

05/04/2026
Date

WAC 388-78A-2703 Safety of the built environment. The assisted living facility must provide a safe environment and promote the safety of each resident whenever the resident is on the premises or under the supervision of staff persons consistent with the resident's negotiated service agreement, and must maintain the premises and equipment used in resident care so as to be free of hazards, including:

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members positioned the resident's bed to a safe height for 1 of 3 sampled residents (Resident 1) reviewed. This failure resulted in Resident 1 falling and sustained a subdural hematoma (a dangerous collection of blood between the brain's surface and its outer covering) and placed the resident at risk for sustaining avoidable injuries and harm.

Findings included...

Record review of facility resident records for Resident 1, showed the facility admitted the resident on [redacted] 2026 with diagnoses including [redacted] and [redacted].

Review of Resident 1's negotiated service agreement, dated 04/02/2026, documented the resident's cognition was impaired, confused and could not understand others. Resident 1 was dependent on staff members for assistance with their activities of daily living including transfer and mobility. The resident had a history of falls and hip fractures.

Review of an incident investigation, dated 04/05/2026 at 7:00 AM, showed that staff

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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.

Residential Care Services | 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

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This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to ensure staff members positioned the resident's bed to a safe height for 1 of 3 sampled residents (Resident 1) reviewed. This failure resulted in Resident 1 falling and sustained a subdural hematoma (a dangerous collection of blood between the brain's surface and its outer covering) and placed the resident at risk for sustaining avoidable injuries and harm.

Findings included...

Record review of facility resident records for Resident 1, showed the facility admitted the resident on [redacted]/2026 with diagnoses including [redacted] and [redacted].

Review of Resident 1's negotiated service agreement, dated 04/02/2026, documented the resident's cognition was impaired, confused and could not understand others. Resident 1 was dependent on staff members for assistance with their activities of daily living including transfer and mobility. The resident had a history of falls and hip fractures.

Review of an incident investigation, dated 04/05/2026 at 7:00 AM, showed that staff

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documented the resident was found on the floor in their room. The resident was blind, deaf, confused, and could not say what had happened. The resident sustained a gash to forehead and left arm. The resident was transported to the hospital. The resident's bed was left in a high position.

Review of the resident's hospital record, dated [redacted]/2026, documented the resident was admitted to the hospital with diagnoses including [redacted] The resident was placed on comfort care.

Review of R1's progress notes, dated 04/05/2026 at 7:00 AM and 12:45 PM, Staff D, Medication Tech, documented the resident was found face down on the floor. The resident's bed was left at an unsafe height. The resident sustained a gash to the forehead and left arm, and had blood shot eyes and their catheter (a tube inserted to help drain urine) bag tube was pulled when they fell out of bed. On 04/08/2026 at 12:45 PM, staff documented the resident returned from the hospital and placed on comfort care. The resident passed away on 04/10/2026.

In an interview on 04/28/2026 at 8:58 AM, Staff B, Caregiver, stated they checked on the resident around 7:00 AM on 04/05/2026 and found the resident on their stomach, by their bed and the bed was left "really high" and was not locked. Staff B stated the resident needed assistance to transfer and was prone of falling out of bed. Staff B stated that the staff member who assisted the resident was responsible for lowering the residents' bed back to the lowest position. Staff B stated Resident 1's bed had to be manually lowered and locked.

Observation of a bed like Resident 1's on 04/28/2026 at 8:58 AM, with Staff B, showed the lowest bed position was 24 inches in height and had to be manually lowered. Staff B demonstrated the bed position at the time when Staff B found the resident on 04/05/2026 at 7:00 AM and was measured at 36 inches in height.

In an interview on 04/28/2026 at 9:11 AM, Staff C, Caregiver, stated that they had been trained to set the residents' beds at the height that residents were able to get in and out of their beds safely. Staff C stated staff members were responsible for setting the residents' beds at a proper height and locked.

In an interview on 04/28/2026 at 9:19 AM, Staff A, Resident Care Coordinator, stated that staff members had been trained to lower the residents' beds to where residents were able to get out of bed safely. Staff A stated staff members had been trained to operate the beds, and it was common sense to lower residents' beds.

In an interview on 04/28/2026 at 10:47 AM, Staff D stated on 04/05/2026 at 7:00 AM care staff informed Staff D Resident 1 was on the floor and could not tell what had

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happened. Staff D said they noticed the bed was left in a high position. Staff D stated Staff D was 5 feet 6 inches tall and the top of the bed was at their waist or higher height. Staff D said staff members had to manually crank to raise and lower the bed and Resident 1 could not perform the task. Staff D stated they had been trained to operate the bed and to lower the bed to a safe position and lock the bed when done with 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) 06/12/2026.

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

Administrator

Administrator (or Representative) Date 05/04/2026

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