STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

02/12/2025

EMERITUS CORPORATION
Brookdale Torbett
221 Torbett St
Richland, WA 99354

RE: Brookdale Torbett # 2325

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 54389 (Completion Date 02/12/2025) and 51622 (Completion Date 12/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/12/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

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

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(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

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

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in (e) of this subsection, the facility must provide an outdoor area for residents that:

(iii) Has areas protected from direct sunshine and rain throughout the day;

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

WAC 388-112A-0080 Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090 : Adult family homes.

(5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training. Enhanced services facilities.

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when? Unless exempt under WAC 246-980-025 , the following individuals must be certified by the department of health as a home care aide within the required time frames:

(1) All long-term care workers, within two hundred days of the date of hire;

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each

staff person is screened for tuberculosis within three days of employment.

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(b) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

The Department staff who did the On Site verification:
Elizabeth Hall, AFH/ALF Licensor
Robin Rainville, Assisted Living Facility Licensor

If you have any questions, please contact me at (509)225-2823.

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Torbett
Provider Type: Assisted Living Facility
License/Cert.#: 2325
Compliance Determination #: 51622
Intake ID: 155445
Investigator: Robin Rainville
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 12/09/2024 through 12/23/2024
Complainant Contact Date(s):

Allegation(s):

1. A named staff member violated HIPAA when they spoke to a non-staff member about the named resident.
2. Concern of a dangerous resident living in the facility.

Investigation Methods:

Sample:	Total residents: 45 Resident sample size: 7 Closed records sample size: 0
Observations:	Sampled resident rooms, common areas, resident to resident and resident to staff interactions.
Interviews:	Facility staff, sampled residents, and others not associated with the facility.
Record Reviews:	Facility characteristic roster, resident records (assessments, care plans, progress notes, medication/treatment administration records, temporary service plans), incident investigations, facility policies, staff records and as work schedules, disclosure of services, menus, and disaster plan.

Investigation Summary:

1. Interview with the facility administrator showed that they were unaware of a staff member who violated resident confidentiality and investigated the allegation. Further staff interviews showed no knowledge of resident confidentiality being breached. Interviews with sampled resident family members showed they were satisfied with the care and services the facility provided. Additionally, family members stated that staff were respectful and professional. No facility failed practice identified.
2. Interview with facility administration showed that the facility was a specialized dementia unit and residents were assessed for their care needs prior to moving into the facility. Record review showed that not all incidents were being investigated. Failed practice identified. See Statement of Deficiencies dated 12/23/2024, Washington Administrative Code (WAC) 388-78A-2371(1)(2)(3) Investigations.

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
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2325	Compliance Determination # 51622
Plan of Correction	Brookdale Torbett	Completion Date
Page 1 of 29	Licensee: EMERITUS CORPORATION	12/23/2024

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 the unannounced on-site full inspection and complaint investigation on 12/09/2024, 12/10/2024, 12/11/2024, 12/12/2024 and 12/13/2024 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint numbers: 155445.

The following sample was selected for review during the unannounced on-site visit: 7 of 45 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Elizabeth Hall, AFH/ALF Licensor
Elaine Lopez, Licensor
Robin Rainville, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

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.

Laura Williams-Davis
Residential Care Services

12/24/2024
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: 12/30/24

WAC 388-78A-2371 Investigations. The assisted living facility must:

(1) Investigate and document investigative actions and findings for any alleged or suspected abuse, neglect, or financial exploitation; or accident or incident jeopardizing or affecting a resident health or life;

(2) Determine the circumstances of the event;

(3) When necessary, institute and document appropriate measures to prevent similar future situations if the alleged incident is substantiated; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to investigate and document investigative actions, and institute fall preventative measures for 4 of 4 residents (Resident 1 2, 5 and 7). These failures placed residents at risk of further injuries or falls.

Findings included...

Review of the facility's policy, "Incident Reporting Policy," revised 01/2024, showed that the facility staff member was to complete the preliminary notes of an incident or enter the incident into the facility's incident reporting system. The policy showed that a management member should review and lock the incident no later than three business days after the data is entered.

In an interview on 12/11/2024 at 10:58 AM, Staff J stated that the facility should have investigations for falls and altercations.

<Resident 1>

Review of Resident 1's demographic page, undated, showed that the resident moved into the facility on [redacted]/2024. The demographic page also showed Resident 1 had a diagnosis of [redacted].

Resident 1's record included a temporary service plan (TSP), dated 11/22/2024, that showed the resident had been sent out to the hospital for evaluation of the injury to

their head and had a 1.5-inch laceration. The record did not show an investigation for the 11/22/2024 incident had been completed.

Review of Resident 1's progress note, dated 11/23/2024, showed the resident had returned from the hospital at 04:39 AM, due to a fall with a laceration to their scalp.

In an interview on 12/10/2024 at 11:30 AM, Staff J, Licensed Practice Nurse/Area Regional Nurse, stated that they were unable to find an investigation for Resident 1's fall that occurred on 11/22/2024.

Resident 1's record included a TSP, dated 11/27/2024 which showed that the resident displayed physical aggression towards staff and family. The TSP showed that the facility called the local fire department for the resident to be sent to the hospital. The record did not show that an investigation for the 11/27/2024 incident had been completed.

Resident 1's record included a TSP, dated 11/29/2024 which showed that Resident 1 got into a physical altercation with another resident. The record did not show that an investigation for the 11/29/2024 incident had been completed.

In an interview on 12/11/2024 at 2:05 PM, Staff J, stated that they were not able to find investigations for the 11/27/2024 and 11 /29/2024 incidents involving Resident 1.

<Resident 2>

Review of Resident 2's demographic page, undated, showed that the resident moved into the facility on [redacted]/2024. The demographics page also showed that Resident 2 had a diagnosis of [redacted].

Review of Resident 2's 11/20/2024 TSP showed that the resident was being, "inappropriate," with residents and staff. The TSP showed that staff were to monitor and redirect the resident. Resident 2's record did not show that an investigation for the 11/20/2024 incident had been completed.

Review of Resident 2's 11/29/2024 TSP showed that Resident 2 got into a physical altercation with another resident. The TSP showed that staff were to monitor and redirect the resident. Resident 2's record did not show that an investigation for the 11/29/2024 incident had been completed.

In an interview on 12/11/2024 at 3:00 PM, Staff J, stated that they could not find the 11/20/2024 and 11/29/2024 incident investigations for Resident 2.

<Resident 5>

Review of Resident 5's demographics page, undated, showed that the resident moved into the facility on [redacted]/2023. The page also showed that Resident 5 had a diagnosis of [redacted] and [redacted].

Review of Resident 5's TSP dated 10/12/2024, showed that the resident had a fall with multiple skin tears. The TSP further stated, "Interventions indicated by investigation," with no interventions listed.

Review of Resident 5's progress note, dated 11/03/2024, showed that the resident was physically aggressive towards staff and three other residents.

Review of Resident 5's TSP, dated 11/09/2024, showed that the resident had hit another resident in the head.

Review of Resident 5's TSP, dated 11/17/2024, showed that the resident had a fall in their room. The TSP did not show any interventions to prevent further falls.

Review of Resident 5's TSP, dated 11/21/2024, showed that the resident had a fall with a skin tear to their middle finger. The TSP did not show any fall interventions.

Review of Resident 5's progress note, dated 11/26/2024, showed that the resident had returned from the hospital at 4:34 AM, due to receiving a cut to their scalp.

Resident 5's record included a TSP, dated 11/26/2024, which showed that the resident had been sent out to the hospital for evaluation after a fall with injury to their head and had received staples to close the wound.

Review of Resident 5's record showed that it did not include investigations and interventions for their four fall incidents and two altercations.

In an interview on 12/11/2024 at 2:09 PM, Staff J stated that they were unable to find any further documentation regarding Resident 5's incidents dated 10/12/2024, 11/03/2024, 11/09/2024, 11/17/2024, 11/21/2024, or 11/26/2024.

<Resident 7>

Review of Resident 7's demographics page, undated, showed that the resident moved into the facility on [redacted]/2024. The page also showed that Resident 7 had a diagnosis of [redacted].

Review of Resident 7's TSP, dated 11/17/2024, showed that the resident had an altercation with another resident that resulted in a bruise and pain to the back of their head.

Review of Resident 7's record showed that it did not include an investigation and interventions regarding their resident-to-resident altercation.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/6/25 .

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

Administrator (or Representative) — Date: 12/30/24

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

(2) Identify any changes in the resident's physical, emotional, and mental functioning that are a:

(a) Departure from the resident's customary range of functioning; or

(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

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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to observe, evaluate, and take appropriate action for a resident who had a change in their physical condition, for 1 of 1 resident (Resident 6). This failure placed the resident at risk of complications from their skin condition and placed other residents and staff at risk of contracting a contagious disease.

Findings included...

Review of Resident 6's progress note, dated 10/08/2024, showed that Resident 6 had "areas of concern" to their right forearm. The progress note showed that the resident's physician had ordered a test for scabies (a contagious parasitic infestation caused by

tiny mites that burrow into the skin and lay eggs, causing intense itching and a rash) and the resident was placed on isolation precautions.

Review of Resident 6's progress note, dated 10/22/2024, showed that the resident had red, itchy bumps on their lower extremities and torso and was placed back on isolation precautions.

A review of Resident 6's record, completed on 12/13/2024, showed no documentation of the results of the testing of the suspected scabies rash, no treatment for the suspected scabies rash and no follow up with any nurse or physician. Resident 6's record did not show that the resident was monitored for their contagious skin condition.

In an interview on 12/11/2024 at 3:14 PM, Staff J, Licensed Practical Nurse/Area Nurse Manager, stated that they were unable to locate any documentation to show that Resident 6 had been tested, treated or monitored for their rash.

Observation on 12/12/2024 at 10:58 AM showed that Resident 6 had multiple red, open and scabbed areas on their right forearm. Resident 6 was observed to scratch at both of their arms and their torso.

In an interview on 12/12/2024 at 10:59 AM, Resident 6 stated that they were itchy and uncomfortable.

In an interview on 12/13/2024 at 11:49 AM Staff A, Administrator, stated that they had sent Resident 6 to the Emergency Room that morning, for evaluation of their skin.

In an interview on 12/23/2024 at 2:42 PM, Staff A stated that Resident 6 had returned to the facility on 12/13/2024 with a diagnosis of [redacted] and doctor's orders for medication to treat a scabies infection.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/10/25 .

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

Sarah McCall — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

(b) If the assisted living facility provides medication administration services, each resident who requires medication administration and his or her negotiated service agreement indicates the assisted living facility will provide medication administration.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure medication was given as prescribed and failed to develop and ensure a safe medication system was in place for residents who required assistance and administration with their medication for 5 of 7 residents (Resident 1, 3, 4, 5, and 7). These failures resulted in medication errors and placed residents at risk of falls.

Findings included...

Review of the facility's policy titled, "Medication Times: Administration or Assistance Policy," revised 07/2023, showed that medication administration times were determined by a resident's doctor/primary healthcare provider. The policy showed that administration times would be adjusted on the Medication Administration Record (MAR) when specifically ordered to be so. Additionally, the policy showed that entries of orders onto the MARs were to be confirmed by the Health and Wellness Director (HWD).

Review of the ALF's policy titled, "Medication Management," revised 02/15/2024, showed that medications were to be administered at the times ordered by the physician and according to the pharmacy label on the package. The policy showed that staff were to verify that the medication label matched the MAR at the time medications were dispensed to a resident.

In an interview on 12/11/2024 at 2:20 PM, Staff A, Administrator, stated that on 10/26/2024 a Medication Technician (MT) had changed the medication administration times from evening/bedtime to 3:00 PM in the afternoon to be more beneficial for staff. Staff A stated that when they realized the evening/bedtime doses were being given earlier in the day Staff A informed Staff B, Registered Nurse/Health Wellness Director, to change the medication dose times back to evening/bedtime as ordered. Staff A stated that they had not realized that all of the residents' dose times had not been changed

back.

<Resident 7>

Review of Resident 7's full facility assessment, dated 02/01/2024, showed that the resident required staff assistance with their medication. The assessment showed that Resident 7 went out of the facility every Monday, Wednesday and Friday to have dialysis (a treatment that filters the toxins out of the blood stream, needed when a person's kidneys fail). Additionally, the assessment showed that Resident 7 had nerve pain due to diabetes (a disease in which the body does not regulate sugar in the blood stream properly and can lead to kidney failure).

Review of an after-visit summary from Resident 7's doctor, dated 07/01/2024, showed that the resident was to take Losartan (to reduce high blood pressure) on non-dialysis days as needed when top number of the blood pressure (systolic pressure) was over 130. The summary showed that Resident 7 was to take their Gabapentin (to reduce nerve pain) and Atorvastatin (to reduce cholesterol) medications daily at bedtime.

Review of Resident 7's doctor's orders, dated 08/12/2024, showed that Resident 7 was to take Losartan on non-dialysis days, if the systolic blood pressure was over 130. The orders showed that Resident 7 was to take their Gabapentin and Atorvastatin daily at bedtime.

Review of a new order in Resident 7's record, dated 11/04/2024, showed that the resident was to take Losartan on non-dialysis days as needed when their systolic blood pressure was over 130.

Review of Resident 7's October 2024 MAR showed that their blood pressure was checked daily on non-dialysis days. The MAR showed the entry for the Losartan read as follows: Give one tab by mouth on non-dialysis days, "HBP 130 or above." The MAR showed that Resident 7 was given their Losartan on non-dialysis days ten times when their systolic blood pressure was less than 130. The MAR showed that the Losartan was held twice when Resident 7's systolic blood pressure was over 130.

Additionally, Resident 7's October 2024 MAR showed that on 10/26/2024, their Gabapentin and Atorvastatin were ordered as to be given at bedtime, however the administration times were changed from 8:00 PM to 3:00 PM.

Resident 7's record did not show that they had a doctor's order to change their Gabapentin and Atorvastatin administration times from bedtime to 3:00 PM on 10/26/2024.

Review of Resident 7's November 2024 MAR showed the entry for the Losartan read as

follows: Give one tab by mouth on non-dialysis days, "HBP 130 or above" from 11/01/2024 through 11/09/2024. That entry did not show that Resident 7's blood pressure was checked on their non-dialysis days, and showed that Resident 7 was given the medication on 11/05/2024 and 11/07/2024.

Resident 7's November 2024 MAR showed that a new entry for their Losartan was written on 11/09/2024, as needed on non-dialysis days for systolic blood pressure over 130. The new entry did not include a box for the resident's blood pressure to be checked.

Additionally, Resident 7's November 2024 MAR showed that their Gabapentin and Atorvastatin were ordered to be given at bedtime, however they were given at 3:00 PM daily.

Review of Resident 7's December 2024 MAR showed the order for the Losartan was as needed on non-dialysis days for systolic blood pressure over 130. The MAR did not include a box for the resident's blood pressure to be checked.

Additionally, Resident 7's December 2024 MAR showed that their Gabapentin and Atorvastatin were ordered to be given at bedtime, however they were given at 3:00 PM daily.

In an interview on 12/11/2024 at 2:11 PM, Staff J, Licensed Practical Nurse/Area Nurse Manager, stated that they did not know why residents' medication administration times were changed to 3:00 PM in October 2024.

In an interview on 12/12/2024 at 11:28 AM, Staff J stated that the facility did not have a policy on checking orders on MARs for accuracy. Staff J stated that medication technicians could enter new orders onto the MARS and entries should be double checked by the nurse/HWD.

In an interview on 12/12/2024 at 11:56 AM, Staff J stated that Resident 7's Losartan order should have been clarified with the resident's doctor. Staff J stated that Resident 7's blood pressure should be checked daily on non-dialysis days, with direction to give the Losartan when the resident's systolic blood pressure was over 130. Staff J acknowledged that in November 2024 and December 2024, Resident 7's blood pressure was not checked to see if they needed to be given the Losartan.

In an interview on 12/12/2024 at 3:09 PM, Staff J stated that they would investigate Resident 7's Losartan orders, as it appeared to be medication administration errors in October 2024. Staff J acknowledged that the October MAR showed that Resident 7's Losartan had been given when their systolic blood pressure was under 130 and had been held when it was over 130.

<Resident 1>

Review of Resident 1's Negotiated Service Agreement (NSA), dated 12/04/2024, showed that the resident required staff administration of their medication due to their Alzheimer's disease (a progressive brain disorder which causes impairment with memory, language and judgement).

Review of Resident 1's doctor's order, dated 10/31/2024, showed the following medication orders: Quetiapine (for behaviors) at bedtime and Flomax (for urinary retention) once a day with dinner.

Review of Resident 1's November 2024 MAR showed the following medications were given to Resident 1 at 3:00 PM, instead of at evening as ordered:

-Quetiapine was given at 3:00 PM on 11/07/2024 through 11/12/2024 and 11/16/2024 through 11/30/2024 (a total of 21 doses were given at 3:00 PM instead of at bedtime as the doctor ordered).
-Flomax was given at 3:00 PM on 11/07/2024 through 11/10/2024, 11/16/2024 through 11/30/2024, (a total of 19 doses given at 3:00 PM instead of at dinner time as ordered).

Review of Resident 1's December 2024 MAR showed the following medications were given to Resident 1 at 3:00 PM instead of evening as ordered:

-Quetiapine was given at 3:00 PM on 12/01/2024 and 12/02/2024 instead of at bedtime as ordered.
-Flomax was given at 3:00 PM on 12/01/2024, 12/02/2024, 12/03/2024, 12/05/2024, 12/06/2024, 12/07/2024, and 12/08/2024, instead of in the evening as ordered (total of seven doses given at 3:00 PM).

Resident 1's record did not show that they had a doctor's order to change their medication administration times from evening/bedtime to 3:00 PM on 10/26/2024.

<Resident 3>

Review of Resident 3's NSA, dated 10/01/2024, showed that the resident required staff assistance with their medication due to their Alzheimer's disease. The NSA showed that Resident 3 had high blood pressure.

Review of Resident 3's doctor's order, dated 08/03/2024, showed the following medication orders: Eye drops two drops in both eyes in the morning and evening for irritated eyes; Flomax daily at bedtime; prazosin daily at bedtime for high blood

pressure; trazodone daily at bedtime for sleep.

Review of Resident 3's October 2024 MAR showed the evening/bedtime medication doses were changed from 8:00 PM to 3:00 PM beginning 10/26/2024.

Review of Resident 3's October 2024 MAR showed the following medications were given to Resident 3 at 3:00 PM, instead of evening or bedtime as the doctor ordered:

-eye drops were given at 3:00 PM from 10/26/2024 through 10/31/2024, a total of 6 doses.
-Flomax was given at 3:00 PM starting on 10/26/2024 through 10/31/2024, a total of 6 doses.
-prazosin was given at 3:00 PM from 10/26/2024 through 10/31/2024, a total of 6 doses.
-trazodone was given at 3:00 PM from 10/26/2024 through 10/31/2024, a total of 6 doses.

Review of Resident 3's November 2024 MAR showed the following medications were given to Resident 3 at 3:00 PM, instead of evening or bedtime as the doctor ordered:

-eye drops were given at 3:00 PM from 11/01/2024 through 11/11/2024 and 11/13/2024 through 11/30/2024, a total of 29 doses.
-flomax was given at 3:00 PM starting on 11/01/2024 through 11/11/2024 and 11/13/2024 through 11/30/2024, a total of 29 doses.
-prazosin was given at 3:00 PM from 11/01/2024 through 11/11/2024 and 11/13/2024 through 11/30/2024, a total of 29 doses.
- trazodone was given at 3:00 PM from 11/01/2024 through 11/11/2024 and 11/13/2024 through 11/30/2024, a total of 29 doses.

Review of Resident 3's December 2024 MAR showed the following medications were given to Resident 3 at 3:00 PM, instead of evening or bedtime as the doctor ordered:

-eye drops were given at 3:00 PM on 12/01/2024 and 12/02/2024, and from 12/04/2024 through 12/08/2024, a total of seven doses.
-flomax was given at 3:00 PM starting on 12/01/2024 through 12/08/2024, a total of eight doses.
-prazosin was given at 3:00 PM from 12/01/2024 through 12/08/2024, a total of eight doses.
- trazodone was given at 3:00 PM from 12/01/2024 through 12/08/2024, a total of eight doses.

Resident 3's record did not show that they had a doctor's order to change their medication administration times from evening/bedtime to 3:00 PM on 10/26/2024.

<Resident 4>

Review of Resident 4's NSA, dated 12/09/2024, showed that the resident required staff assistance with their medication due to cognitive impairment related to their dementia. The NSA also showed that Resident 4 had diagnoses of [redacted] and [redacted].

Review of Resident 4's doctor's order, dated 09/28/2024, showed the following medication orders: Melatonin at bedtime for sleep aid; metoprolol one time a day for high blood pressure, with additional instruction to hold the medication if the resident's blood pressure was less than 100/60.

Resident 4's blood pressure not being taken as ordered:

Review of Resident 4's October 2024 MAR showed that their metoprolol was changed on the MAR to be given from 5:00 AM to 6:00 AM from 10/27/2024 through 10/31/2024. The MAR also showed that Resident 4's blood pressure was not taken when the metoprolol was given from 10/27/2024 through 10/31/2024.

Review of Resident 4's November 2024 MAR showed that their metoprolol was given at 6:00 AM from 11/01/2024 through 11/30/2024. The MAR also showed that Resident 4's blood pressure was not taken when the metoprolol was given from 11/01/2024 through 11/30/2024.

Review of Resident 4's December 2024 MAR showed that their metoprolol was given at 6:00 AM from 12/01/2024 through 12/10/2024, a total of 10 doses. The MAR also showed that Resident 4's blood pressure was not taken when the metoprolol was given from 12/01/2024 through 12/10/2024.

Resident 4's medications not given at bedtime as ordered:

Review of Resident 4's October 2024 MAR showed that their melatonin was given at 3:00 PM instead of at bedtime as the doctor ordered, from 10/26/2024 through 10/31/2024, for a total of 6 doses

Review of Resident 4's November 2024 MAR showed that their melatonin was given at 3:00 PM instead of at bedtime as the doctor ordered, from 11/01/2024 through 11/30/2024, a total of 30 doses.

Review of Resident 4's December 2024 MAR showed that their melatonin was given at 3:00 PM instead of at bedtime as the doctor ordered, from 12/01/2024 through

12/09/2024, a total of 9 doses.

Resident 4's record did not show that they had a doctor's order to change their medication administration times from evening/bedtime to 3:00 PM on 10/26/2024.

<Resident 5>

Review of Resident 5's NSA, dated 12/04/2024, showed that the resident required staff assistance with their medications.

Review of Resident 5's doctor's orders dated 10/25/2024, showed an order for Lorazepam (a medication used to treat anxiety disorders with common side effects of dizziness, drowsiness, falls and weakness) to be given at bedtime.

Review of Resident 5's October 2024 MAR showed that the Lorazepam bedtime dose was changed from 8:00 PM to 3:00 PM beginning on 10/26/2024. The MAR showed that the Lorazepam was given to Resident 5 for agitation and insomnia.

Review of Resident 5's October 2024 MAR showed that the Lorazepam was given at 3:00 PM from 10/26/2024 through 10/31/2024, instead of at bedtime as ordered, for a total of 6 doses.

Review of Resident 5's November 2024 MAR showed that the Lorazepam was given at 3:00 PM 11/01/2024 through 11/03/2024, instead of at bedtime as ordered, for a total of 4 doses.

<Resident 6>

Review of Resident 6's NSA, dated 10/01/2024, showed that the resident required staff administration of their medication. The NSA showed that Resident 6 had a diagnosis of [redacted].

Review of Resident 6's doctor's order, dated 10/02/2024, showed that the resident was prescribed Mirtazapine (for depression and difficulty sleeping which cause drowsiness and dizziness) daily at bedtime.

Review of Resident 6's October 2024 MAR showed that the Mirtazapine administration time was changed on 10/26/2024 to 3:00 PM instead of at bedtime as ordered. The MAR showed that the Mirtazapine was administered at 3:00 PM from 10/26/2024 to10/31/2024, a total of 6 doses.

Review of Resident 6's November 2024 MAR showed that the Mirtazapine was administered to Resident 6 at 3:00 PM instead of at bedtime as ordered from 11/01/2024 to 11/30/2024, a total of 30 doses.

Review of Resident 6's December 2024 MAR showed that the Mirtazapine was administered to Resident 6 at 3:00 PM instead of at bedtime as ordered from 12/01/2024 to 12/08/2024, a total of 8 doses.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/Ce/2025.

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

Sarah McCallum — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that medication technicians who were administering medication, were nurse delegated for 2 of 2 residents (Resident 3 and 6). This failure placed residents at risk of complications of their chronic health conditions and delegated tasks being performed incorrectly.

Findings included...

Review of Washington Administrative Code (WAC) 246-840-930 showed that the Registered Nurse Delegator (RND) would verify that a Medication Technician (MT) was properly certified in Washington state and had completed nurse delegation training. The WAC showed that the RND would assess the MT for competency for performing the delegated tasks.

In an interview on 12/12/2024 at 1:10 PM Staff L, RND, stated that all delegation documentation would be found in the delegation binder. Staff L stated that when a staff

member or resident required delegation the facility would contact Staff L and they would come to the facility and provide the necessary training/assessments.

Review of the facility's delegation binder, completed on 12/13/2024, showed no documentation that the RND had verified the credentials and nurse delegation training for Staff G, MT, Staff H, MT, or Staff I, MT.. The delegation binder did not show that the RND had delegated nursing tasks for Resident 3 and Resident 6 to Staff G, H, or I.

In an interview on 12/12/2024 at 2:42 PM, Staff A, Administrator, stated that Staff G, H, and I were not delegated MT's.

In an interview on 12/12/2024 at 2:43 PM, Staff K, Business Office Coordinator, stated that Staff G, H, and I did not have their delegation training certifications.

<Resident 3>

Review of Resident 3's full facility assessment, dated 07/30/2024, showed that the resident required nurse delegation for administration of crushed oral medications, eye drops, and nasal spray due to inability to self-direct their medications. The assessment showed that delegated MTs must administer those medications. Resident 3's assessment showed that the resident had a diagnosis of [redacted].

Review of Resident 3's doctor's order, dated 08/06/2024, showed that Resident 3 was prescribed 16 oral medications, one topical medicated ointment, one medicated eye drop and one nasal spray.

Review of Resident 3's October 2024 Medication Administration Record (MAR) showed that Staff H, MT, had given Resident 3 the following medication in October:

10/05/2024: All morning oral medications, eye drops, nasal spray, and a topical medicated powder.
10/10/2024: two oral morning medications
10/19/2024: two oral morning medications
10/29/2024: All morning oral medications, eye drops, and nasal spray

<Resident 6>

Review of Resident 6's full facility assessment, dated 07/08/2024, showed that the resident required nurse delegation for administration of crushed oral pills, topical creams/powders/ointments, and blood sugar checks (finger stick test to determine levels of sugar in the blood) due to inability to self-direct care. The assessment showed

that delegated MTs must administer those medications. Resident 6's assessment showed that the resident had a diagnosis of [redacted] and [redacted].

Review of Resident 6's doctor's order, dated 10/02/2024, showed that Resident 6 was prescribed seven oral medications, three topical medicated powders/ointments, and daily blood sugar checks. The order for the blood sugar checks included direction to notify Resident 6's doctor if blood sugars were above 400 or below 80.

Review of Resident 6's October 2024 MAR showed that Staff H had administered the following medications and/or treatments:

10/05/2024: two oral medications and administered the finger stick blood sugar test with a result of 78.
10/29/2024: two oral medications and administered the finger stick blood sugar test with a result of 78.

Review of Resident 6's record showed no documentation that their doctor was notified when their blood sugar was less than 80 on 10/05/2024 or 10/29/2024.

Review of Resident 6's November 2024 MAR showed that Staff G, MT, had administered the following medications and/or treatments:

11/01/2024: administered the finger stick blood sugar test with a result of 85.
11/19/2024: two oral medication and administered the finger stick blood sugar test with a result of 95.

Review of Resident 6's November 2024 MAR showed that Staff I, MT, had administered the following medications and/or treatments:

11/06/2024: two oral medications and administered the finger stick blood sugar test with a result of 128.
11/07/2024: two oral medications and administered the finger stick blood sugar test with a result of 90.
11/08/2024: four oral medications
11/09/2024: four oral medications
11/12/2024: two oral medications and administered the finger stick blood sugar test with a result of 176.
11/14/2024: four oral medications
11/15/2024: five oral medications
11/20/2024: four oral medications
11/21/2024: four oral medications
11/27/2024: four oral medications

Review of Resident 6's December 2024 MAR showed that Staff I had administered the following medications and/or treatments:

12/01/2024: two oral medications and documented, "Other/see nurse note" for the finger stick blood sugar test. Review of Resident 6's nursing notes showed no entries for the missed blood sugar check on 12/01/2024.
12/02/2024: five oral medications
12/03/2024: four oral medications
12/06/2024: six oral medications
12/07/2024: two oral medications
12/08/2024: four oral medications

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/10/25 .

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

Sarah McCallum — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2381 General design requirements for memory care.

(2) The facility must provide common areas, including at least one resident accessible common area outdoors. Such common areas should accommodate and offer the opportunity of social interaction, stimulate activity, contain areas with activity supplies and props to encourage engagement, and have safe outdoor paths to encourage exercise and movement.

(a) These areas must have a residential atmosphere and must accommodate and offer opportunities for individual or group activity including:

(iv) Ensuring residents have access to their own rooms at all times without staff assistance.

(b) Unless an alternative viewing area is provided as described in (c) of this subsection and written policies and procedures are created as described in (e) of this subsection, the facility must provide an outdoor area for residents that:

(iii) Has areas protected from direct sunshine and rain throughout the day;

This requirement was not met as evidenced by:

Based on observation and interview, the facility failed to ensure residents had access to their room without staff assistance for 1 of 7 residents (Resident 7). Additionally, the

ALF failed to ensure residents had access to outdoor areas that provide protection from rain and sun, for 2 of 2 outdoor courtyards (100s side and 200s side). This failure denied the residents their rights to have free access to their personal space and belongings and to be outdoors during rain and excessive sunny weather.

Findings included...

<Doors locked>

In an interview on 12/10/2024 at 4:39 PM, Collateral Contact 1 (CC1) stated that the door to Resident 7's room was always kept locked. CC1 stated that Resident 7 used to have a key but due to their dementia, they had lost it. CC1 stated that they did not like having to ask staff for assistance to get into Resident 7's room.

Observation on 12/12/2024 at 11:30 AM showed Resident 7 walking independently with their walker.

Observation on 12/12/2024 at 11:34 AM showed that a caregiver had to use a key to open Resident 7's door.

Observation on 12/13/2024 at 11:06 AM showed that Resident 7's apartment door was locked on the outside. Staff A, Administrator, used a key to open Resident 7's locked door.

In an interview on 12/13/2024 at 11:59 AM, Staff A stated that they don't normally keep Resident 7's door locked.

Observation on 12/13/2024 at 12:10 PM showed that all but one resident room doors on the 200s side of the facility were locked.

<Courtyards>

Observation on 12/09/2024 at 12:55 PM showed that the courtyard on the 100s side of the facility did not have a covered area to protect residents who went outside from rain and sun.

Observation on 12/09/2024 at 1:50 PM showed that the courtyard on the 200s side of the facility did not have a covered area to protect residents who went outside from rain and sun.

In an interview on 12/13/2024 at 12:51 PM, Staff J Licensed Practical Nurse/Area Nurse

Manager, stated that if they had known the courtyards needed a covered area they would not have taken down the canopy cover.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/6/25 .

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

Karen McCall — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2450 Staff.

(2) The assisted living facility must:

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff received facility orientation, for 4 of 4 staff (Staff A, B, C and D). This failure placed residents at risk of being cared for by untrained staff.

Findings included...

Review of the personnel file for Staff A, Administrator, showed that they were hired on 06/03/2024. Staff A's file did not show that they had received facility orientation.

Review of the personnel file for Staff B, Registered Nurse/Health and Wellness Director, showed that they were hired on 11/27/2023. Staff B's file did not show that they had received facility orientation.

Review of the personnel file for Staff C, Claire Bridge Coordinator/Activities Director, showed that they were hired on 01/23/2023. Staff C's file did not show that they had received facility orientation.

Review of the personnel file for Staff D, Medication Technician, showed that they were hired on 08/27/2024. Staff D's file did not show that they had received facility orientation.

In an interview on 12/12/2024 at 1:24 PM, Staff K, Business Office Coordinator, stated the facility did not have any documentation to show that staff had completed facility orientation.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/10/25.

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

Sarah McCallum — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2466 Background checks Washington state name and date of birth background check Valid for two years National fingerprint background check Valid indefinitely.

(1) A Washington state name and date of birth background check is valid for two years from the initial date it is conducted. The assisted living facility must ensure:

(a) A new DSHS background authorization form is submitted to the department's background check central unit every two years for all administrators, caregivers, staff persons, volunteers and students; and

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that a new DSHS background authorization form was submitted every two years for 2 of 3 staff (Staff E and F). This failure placed the residents at risk of being cared for by disqualified staff.

Findings included...

Review of the personnel file for Staff E, Caregiver, showed that they were hired on 08/08/2022. Staff E's file showed that their most recent background check was completed on 07/21/2022. Staff E's file showed that a background check had not been submitted to the department's Background Check Central Unit (BCCU) every two years as required.

Review of the personnel file for Staff F, Lead Caregiver, showed that they were hired on 06/10/2022. Staff F's file showed that their most recent background check was completed on 05/20/2022. Staff F's file showed that a background check had not been submitted to the department's BCCU every two years as required.

In an interview on 12/12/2024 at 2:39 PM, Staff K, Business Office Coordinator, stated that they had forgotten to submit the two-year background checks for Staff E and F.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/16/25.

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

Sarah McCall — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-24681 Background checks Employment Provisional hire Pending results of national fingerprint background check. The assisted living facility may provisionally employ a caregiver and an administrator hired after January 7, 2012 for one hundred and twenty-days and allow the caregiver or administrator to have unsupervised access to residents when:

(2) The results of the national fingerprint background check are pending.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that a fingerprint background was completed within 120 days as required for 1 of 2 provisionally hired staff (Staff C). This failure placed residents at risk of being cared for by disqualified staff members.

Findings included...

The personnel file for Staff C, Claire Bridge Coordinator/Activities Director, showed that they were hired on 01/23/2023. Staff C's file showed that their fingerprint background check was submitted 11/09/2023. Staff C's file showed that there was not a national fingerprint background request submitted for 290 days after they were hired.

On 12/09/2024 at 1:18 PM, observation showed that Staff C assisted residents to sit in the living room for an activity. Observation showed that there were no other facility staff present while Staff C worked with residents.

In an interview on 12/12/2024 at 1:56 PM, Staff K, Business Office Coordinator, stated that Staff C was originally hired to be a caregiver. Staff K stated that they had completed an audit of staff files in November 2023, which was when Staff K found that Staff C's file did not include a fingerprint background check.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/01/25.

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

Sarah McCall — Administrator (or Representative)

12/30/24 — Date

WAC 388-112A-0080 Who is required to complete the seventy-hour long-term care worker basic training and by when? The following individuals must complete the seventy-hour long-term care worker basic training unless exempt as described in WAC 388-112A-0090 : Adult family homes.

(5) Long-term care workers in assisted living facilities within one hundred twenty days of their date of hire. Long-term care workers must not provide personal care without direct supervision until they have completed the seventy-hour long-term care worker basic training. Enhanced services facilities.

WAC 388-112A-0105 Who is required to obtain home care aide certification and by when? Unless exempt under WAC 246-980-025 , the following individuals must be certified by the department of health as a home care aide within the required time frames:

(1) All long-term care workers, within two hundred days of the date of hire;

WAC 388-78A-2474 Training and home care aide certification requirements.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to:

(b) Basic;

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure that caregivers met the long-term care worker training requirements for 2 of 2 staff (Staff C and E). This failure placed the residents at risk of being cared for by untrained staff.

Findings included...

Review of Washington Administrative Code (WAC) 246.980.030 showed that a long-term care worker must submit an application for a Home Care Aid (HCA) certification within 14 days of hire. The WAC showed that long-term care worker training must be completed within 120 days of hire, and the certification must be obtained within 200 days of hire.

Review of a Department's Dear Provider letter, dated 10/23/2023, showed that long term care workers hired between 4/01/2022 and 09/30/2022 were to have long-term care worker training completed by 10/31/2023 and to obtain HCA certification by 10/31/2024. The letter showed that the previous extensions and waivers to the rules put into place during the pandemic were being lifted and training requirements would resume per the regulations.

<Staff C>

Review of the personnel file for Staff C, Claire Bridge Coordinator (CBC)/Activities Director, showed that they were hired on 01/23/2023. The file showed that Staff C had a pending HCA certification. Staff C's file did not show that they had obtained the HCA certification within 200 days of hire.

Review of the Department of Health's provider credential search website on 12/12/2024 showed that Staff C's HCA certification was still pending. Staff C had not obtained an HCA certification.

In an interview on 12/12/2024 at 1:56 PM, Staff K, Business Office Coordinator, stated that Staff C was hired as a caregiver initially and worked in that role for a year before

becoming the CBC. Staff K stated that Staff C performed tasks that would require them to have an HCA certification.

<Staff E>

Review of the personnel file for Staff E, Caregiver, showed that they were hired on 08/02/2022. The file showed that Staff E had completed the long-term care worker training required for HCA certification, on 07/11/2024 (709 days after they were hired).

Review of the Department of Health's provider credential search website on 12/12/2024 showed that Staff E did not have an HCA certification application submitted to the Department (863 days after they were hired).

In an interview on 12/12/2024 at 2:18 PM, Staff K stated that Staff E was hired during the pandemic when the regulations were waived. Staff K stated that they did not know why Staff E did not have an HCA application submitted so that their certification would be pending. Additionally, Staff K stated that Staff E had not taken the HCA test to become certified within the required time frame.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/01/24/25

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

Tonan McCall — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2480 Tuberculosis Testing Required.

(1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure staff were screened for tuberculosis within three days of hired for 2 of 4 staff (Staff C and D). This failure placed residents at risk of being exposed to a communicable disease.

Findings included...

showed that they were hired on 11/27/2023. The personnel filed showed that they had a previous positive tuberculosis (TB) test, and they had a chest x-ray result dated 08/21/2014. The personnel file did not show that Staff B had a chest X-ray performed within seven days.

In an interview on 12/12/2024 at 1:42 PM Staff A, Administrator, stated that Staff B had a history of a positive skin test. Staff A stated that they were not aware of the requirement for a chest X-ray to be done within 7 days.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/6/25.

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

Sarah McCallie — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2690 Electronic monitoring equipment Resident requested use.

(1) Audio or video monitoring equipment may not be installed in the assisted living facility to monitor any resident apartment or sleeping area unless the resident or the residents' representative has requested and consents to the monitoring.

(5) The release of audio or video monitoring recordings by the facility is prohibited. Each person or organization with access to the electronic monitoring must be identified in the resident's negotiated service agreement.

(6) If the resident requests the assisted living facility to conduct audio or video monitoring of his or her apartment or sleeping area, before any electronic monitoring occurs, the assisted living facility must ensure:

(b) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and

(c) The resident and the assisted living facility have agreed upon a specific duration for the electronic monitoring and the agreement is documented in writing.

(7) The assisted living facility must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing, signed and dated by the resident.

Review of the personnel file for Staff C, Claire Bridge Coordinator/Activities Director, showed that they were hired on 01/23/2023. Staff C's file showed an initial TB test was conducted on 03/06/2024 (408 days after their hire date).

In an interview on 12/12/2024 at 1:46 PM, Staff K, Business Office Coordinator, stated that they did not know why the TB screenings were late for Staff C.

Review of the personnel file for Staff D, Medication Technician, showed that they were hired on 08/27/2024. Staff D's file did not show that they had been screened for TB.

In an interview on 12/12/2024 at 2:17 PM Staff A stated that Staff D had a previous two step TB test from another employer. Staff A stated that they did not know that Staff D needed another TB test upon hire.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) 2/6/25 .

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

Sarah McCallum — Administrator (or Representative)

12/30/24 — Date

WAC 388-78A-2485 Tuberculosis Positive test result. When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

(1) Ensure that the staff person has a chest X-ray within seven days;

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure a staff person who had a positive TB test had a chest X-ray within 7 days for 1 of 1 staff (Staff B). This failure placed residents at risk of potential exposure to a communicable disease.

Findings included...

Review of the personnel file for Staff B, Registered Nurse/Health and Wellness Director,

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that electronic monitoring in a resident's sleeping room was in use for a specific time frame under signed and documented consent, and reevaluated quarterly, for 4 of 4 residents (Resident 4, 5, 6 and 7). This failure placed the residents at risk of violation of their rights and privacy.

Findings included...

In an interview on 12/10/2024 at 2:00 PM, Staff A, Administrator, stated that the facility had a video monitoring system installed in some of the residents' rooms. Staff A stated that the system would record video footage for ten minutes before and ten minutes after the system detected that a resident had a fall in their room.

In an interview on 12/10/2024 at 3:00 PM, Staff J, Licensed Practical Nurse/Area Nurse Manager, stated that the facility did not have a policy regarding electronic monitoring in residents' sleeping rooms.

In an interview on 12/10/2024 at 3:01 PM, Staff A stated that the facility did not have documentation to show that consent had been obtained and the need for cameras was reevaluated quarterly for residents who had the electronic monitoring systems in their rooms. Staff A stated that information about the electronic monitoring systems was not documented on the residents' assessments or their Negotiated Service Agreements (NSAs).

<Resident 4>

Observation on 12/12/2024 at 12:25 PM showed that there was a sign posted at the entrance to Resident 4's room to notify residents and staff of the use of an electronic monitoring system.

Review of Resident 4's record showed a form titled, "Resident Consent/Declination to Fall Detection Program," signed by the resident's representative on 06/17/2024.

Resident 4's record did not have another consent completed quarterly for reevaluation of the electronic monitoring. Resident 4's record also did not include documentation to show that the need and time frame of use of the monitoring system had been reevaluated every quarter.

Review of Resident 4's NSA, dated 12/09/2024, showed that it did not include information about the use of the electronic monitoring in the resident's room.

<Resident 5>

Observation on 12/10/2024 at 2:56 PM showed that there was a sign posted at the entrance to Resident 5's room to notify residents and staff of the use of an electronic monitoring system.

Review of Resident 5's record showed a form titled, "Resident Consent/Declination to Fall Detection Program," signed by the resident's representative on 06/14/2024. Resident 5's record showed that another consent for the use of the electronic monitoring system was not signed until 11/13/2024. Resident 5's record did not show that consent was obtained every quarter as required.

Resident 5's record also did not include documentation to show that the need and time frame of use of the monitoring system had been reevaluated every quarter.

Review of Resident 5's NSA, dated 12/04/2024, showed that it did not include information about the use of the electronic monitoring in the resident's room.

<Resident 6>

Observation on 12/10/2024 at 2:58 PM showed that there was a sign posted at the entrance to Resident 6's room to notify residents and staff of the use of an electronic monitoring system.

Review of Resident 6's record showed a form titled, "Resident Consent/Declination to Fall Detection Program," signed by the resident's representative on 06/20/2024. Resident 6's record showed that there was not another consent signed for the use of the electronic monitoring system. Resident 6's record did not show that consent was obtained every quarter as required.

Resident 6's record also did not include documentation to show that the need and time frame of use of the monitoring system had been reevaluated every quarter.

Review of Resident 6's NSA, dated 10/01/2024, showed that it did not include information about the use of the electronic monitoring in the resident's room.

<Resident 7>

In an interview on 12/10/2024 at 5:15 PM, Collateral Contact 1 (CC1) stated that there was an audio and video camera in Resident 7's room, installed by the resident's family.

CC1 stated that Resident 7 had a roommate who at times would lie in Resident 7's bed.

Review of Resident 7's record showed that it did not include any documentation that consent for the use of a camera in the resident's room had been obtained. Resident 7's record also did not include documentation to show that the need and time frame of use of the camera had been evaluated or reevaluated every quarter.

Review of Resident 7's NSA, dated 02/19/2024, showed that it did not include information about the use of the camera in the resident's room.

In an interview on 12/13/2024 at 11:49 AM, Staff A, Administrator, stated that they had not obtained consent for the use of the camera installed in Resident 7's room, from Resident 7's representative or from Resident 7's roommate. Additionally, Staff A stated that the use and time frame of the camera had not been revaluated quarterly nor was it documented on the residents' NSAs.

Observation on 12/13/2024 at 12:00 PM showed that there was a camera installed which faced directly at Resident 7's bed. Resident 7 was observed to have a roommate.

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, Brookdale Torbett is or will be in compliance with this law and / or regulation on (Date) ~~Feb. 6, 2024~~ 2025

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

Sarah McCallen — Administrator (or Representative)

12/30/24 — Date