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

EMERITUS CORPORATION
Brookdale Torbett
221 Torbett St
Richland, WA 99354

RE: Brookdale Torbett License # 2325

Dear Administrator:

This letter addresses Compliance Determination(s) 41196 (Completion Date 05/14/2024) and 38277 (Completion Date 04/04/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 05/14/2024 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-2160

The Department staff who did the on-site verification:
Laurel Knight, Community Complaint Investigator

If you have any questions, please contact me at (509)208-5231.

Sincerely,

Gwin Kaercher

Gwin Kaercher, 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 #: 38277
Intake ID: 122331
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 03/14/2024 through 04/04/2024
Complainant Contact Date(s): 03/14/2024

Allegation(s):

1. Identified resident is not getting assistance with toileting and changing incontinence products.
2. Identified resident has fallen trying to transfer themselves.

Investigation Methods:

Sample:	Total residents: 31 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Resident care equipment Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.

Investigation Summary:

1. The identified resident was observed in the bathroom with their call light on and calling out for help. The facility staff stated they were not always aware when the call light was on as it only goes to the pager that is carried by the medication technician. The pager was in the medication room and was operational. Failed practice was identified. Please see the Statement of deficiency dated 04/04/2024 for WAC 388-78a-2160 for failure to implement the care plan.
2. The identified resident was observed in the bathroom with their call light on and calling out for help. They stated that they had been calling for a long time and were trying to get back to their wheelchair. Facility records showed the resident had a history of falls while in the bathroom. Failed practice was identified. Please see the Statement of deficiency dated 04/04/2024 for WAC 388-78a-2160 for failure to implement the care plan.

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 #: 2325	Compliance Determination # 38277
Plan of Correction	Brookdale Torbett	Completion Date
Page 1 of 3	Licensee: EMERITUS CORPORATION	04/04/2024

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 an unannounced on-site complaint investigation on 03/14/2024 and 03/14/2024 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 121857, 122331, 125537

The following sample was selected for review during the unannounced on-site visit: 3 of 31 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Laurel Knight, Community Complaint Investigator

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.

Gwin Kaercher
Residential Care Services

04/11/2024
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.

Statement of Deficiencies	License #: 2325	Compliance Determination # 38277
Plan of Correction	Brookdale Torbett	Completion Date
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Heather Steiling
HS
Administrator (or Representative)

4-22-24
Date

WAC 388-78A-2160 Implementation of negotiated service agreement. The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to provide care as indicated on the Negotiated Service Agreement (NSA) for 1 of 2 residents (Resident 1) who required assistance with their activities of daily living (ADL's). This failure resulted in Resident 1 not receiving assistance from staff in a timely manner.

Findings included...

Review of Resident 1's NSA dated 10/09/2023 showed that the resident required assistance from one or two staff to complete their ADL's including dressing, bathing, and toileting. The resident's diagnoses included [redacted] and [redacted]. The NSA showed that Resident 1 needed staff to provide bathroom assistance two or three times per shift and as needed. The NSA showed that Resident 1 was a maximum assist and needed assistance of two people for all transfers.

Review of Resident 1's record showed a chart note on 01/30/2024 at 6:12 PM that documented that Resident 1 fell in the bathroom while trying to transfer independently.

In an interview on 03/14/2024 at 8:25 AM, Resident 1's Collateral Contact (CC1) stated that Resident 1 would put their call light on, and it would stay on for long periods of time. CC1 stated that Resident 1 was often left on the toilet for extended periods of time and had fallen a few times while trying to get back into their wheelchair by themselves.

Observation of Resident 1's room on 03/14/2023 at 11:25 AM showed that the resident was heard from the bathroom calling out "help". Resident 1 was sitting on the toilet looking like they were trying to stand up on their own. They stated, "I pulled the call light cord a long time ago and no one has come to help me."

Statement of Deficiencies	License #: 2325	Compliance Determination # 38277
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In an interview on 03/14/2024 at 11:40 AM with Staff B, Caregiver stated that they were unable to hear Resident 1's 03/14/2024 at 11:25 AM call light from the common area where they were assisting another resident. They stated that this included all resident rooms, all the time.

In an interview on 03/14/2024 at 11:45 AM Staff C, Resident Care Coordinator stated that they were working the medication cart and didn't hear the 03/14/2024 at 11:25 all for assistance via pager because they were out giving medication. The pager was observed in the medication room and clipped to the medication cart.

In an interview on 03/14/2024 at 11:58 AM, Staff A, Registered Nurse stated that the call lights would ring to a pager to notify the medication technician that there was a call light, and the MT would notify the care staff working on the floor. Staff A stated that they were able to confirm the pager worked. They stated that they would determine why there was only one pager available.

This is a recurring deficiency previously cited on 12/15/2023.

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) 4-26-24 .

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

Heather Stepling — Administrator (or Representative)

4-22-24 — Date