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) 44087 (Completion Date 07/16/2024) and 40439 (Completion Date 05/23/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 07/16/2024 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-2630-1-a, WAC 388-78A-2630-1-b, WAC 388-78A-2630-1

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

If you have any questions, please contact me at (509)572-7394.

Sincerely,

Michelle Closner

Michelle Closner, Field Manager
Region 1, Unit Z
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Torbett
Provider Type: Assisted Living Facility
License/Cert.#: 2325
Compliance Determination #: 40439
Intake ID: 128507
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/26/2024 through 05/23/2024
Complainant Contact Date(s): 04/26/2024, 05/23/2024

Allegation(s):

1. Identified resident was abused by another Identified Resident.

Investigation Methods:

Sample:	Total residents: 34 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.

Investigation Summary:

1. The Identified resident was unable to communicate due to a cognitive disability. Their representative stated that the resident was sexually abused by another resident at the facility and it was not reported. The facility staff stated that they were unaware the incident had to be reported. The facility incident investigation showed the resident was assessed, monitored and assigned a one on one staff for safety. Failed practice identified. Please see the Statement of Deficiency dated 05/23/2024 WAC 388-78a-2630.

Conclusion / Action:

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

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Torbett
Provider Type: Assisted Living Facility
License/Cert.#: 2325
Compliance Determination #: 40439
Intake ID: 128568
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 04/26/2024 through 05/23/2024
Complainant Contact Date(s): 04/26/2024, 05/23/2024

Allegation(s):

1. Identified resident was abused by another resident twice while at the facility.

Investigation Methods:

Sample:	Total residents: 34 Resident sample size: 4 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions
Interviews:	Identified resident Nursing staff Residents Family members
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.

Investigation Summary:

1. The Identified resident was unable to communicate due to a cognitive disability. Their representative stated that the resident was sexually abused by another resident at the facility twice since moving in. The facility staff stated that they were unaware the incident had to be reported. The facility incident investigation showed the resident was assessed, monitored and assigned a one on one staff for safety. Failed practice identified. Please see the Statement of Deficiency dated 05/23/2024 WAC 388-78a-2630.

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

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 04/26/2024 and 05/14/2024 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 128507, 128568

The following sample was selected for review during the unannounced on-site visit: 4 of 34 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 Z
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.

Michelle Closner
Residential Care Services

05/30/2024
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 # 40439
Plan of Correction	Brookdale Torbett	Completion Date
Page 2 of 3	Licensee: EMERITUS CORPORATION	05/23/2024

Administrator (or Representative) 10-4-24 Date

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview, and record review, the Assisted Living Facility (ALF), failed to ensure that each staff person made a report to the department's Complaint Resolution Unit (CRU) hotline and Local Law Enforcement (LLE) when there was an allegation of sexual abuse for 2 of 2 staff (Staff A and B). This failure placed residents at risk of ongoing abuse.

Findings included...

On 04/26/2024, Facility policy titled, "Abuse, Neglect & Exploitation WA-1," revised 05/2021, showed any employee who witnesses or "has reasonable cause to believe" that a resident had been the subject of suspected abuse, neglect, or exploitation, should immediately report the incident to the appropriate supervisor on duty as well as the Department of Social and Health Services (DSHS) Complaint Resolution Unit. In cases where sexual abuse has occurred LLE should be notified.

WAC 388-78A-2020 defines Abuse as the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. Abuse includes sexual abuse, mental abuse, physical abuse, and personal exploitation of a vulnerable adult, and improper use of restraint against a vulnerable adult. Sexual abuse means any form of nonconsensual sexual conduct, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse also includes any sexual conduct between a staff person and a vulnerable adult living in that facility whether or not it is consensual.

Review of the Facility Incident Investigation dated 04/26/2024 showed that Staff B, Activities Coordinator, found Resident 1 lying in bed with another resident and Staff B identified it as sexual abuse. Staff B's interview stated that the other resident had their

Administrator (or Representative) Date

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Based on interview, and record review, the Assisted Living Facility (ALF), failed to ensure that each staff person made a report to the department's Complaint Resolution Unit (CRU) hotline and Local Law Enforcement (LLE) when there was an allegation of sexual abuse for 2 of 2 staff (Staff A and B). This failure placed residents at risk of ongoing abuse.

Findings included...

On 04/26/2024, Facility policy titled, "Abuse, Neglect & Exploitation WA-1," revised 05/2021, showed any employee who witnesses or "has reasonable cause to believe" that a resident had been the subject of suspected abuse, neglect, or exploitation, should immediately report the incident to the appropriate supervisor on duty as well as the Department of Social and Health Services (DSHS) Complaint Resolution Unit. In cases where sexual abuse has occurred LLE should be notified.

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Review of the Facility Incident Investigation dated 04/26/2024 showed that Staff B, Activities Coordinator, found Resident 1 lying in bed with another resident and Staff B identified it as sexual abuse. Staff B's interview stated that the other resident had their

hands inside Resident 1's pants. The incident report showed Staff B immediately separated the residents and brought Resident 1 to the wellness center and notified Staff A, Registered Nurse (RN). The incident investigation showed the facility did not report the allegation of sexual abuse to CRU or LLE.

During an interview on 04/26/2024 at 11:50 AM, Staff B stated that they had found the residents and immediately separated them. Staff B stated that they took the resident who was being touched inappropriately to the wellness center and notified the facility nurse. Staff B did not report the incident to the CRU or LLE.

During an interview on 04/26/2024 at 12:01 PM, Staff A stated that they had not reported the allegation to CRU or LLE after being notified of the observation of sexual abuse. Staff A stated that they had done an investigation which concluded abuse occurred. They stated they had not contacted CRU or LLE because they were new to assisted living and unaware they were required to.

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) 7-5-24 .

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

H. Atiig — Administrator (or Representative)

6-4-24 — Date

hands inside Resident 1's pants. The incident report showed Staff B immediately separated the residents and brought Resident 1 to the wellness center and notified Staff A, Registered Nurse (RN). The incident investigation showed the facility did not report the allegation of sexual abuse to CRU or LLE.

During an interview on 04/26/2024 at 11:50 AM, Staff B stated that they had found the residents and immediately separated them. Staff B stated that they took the resident who was being touched inappropriately to the wellness center and notified the facility nurse. Staff B did not report the incident to the CRU or LLE.

During an interview on 04/26/2024 at 12:01 PM, Staff A stated that they had not reported the allegation to CRU or LLE after being notified of the observation of sexual abuse. Staff A stated that they had done an investigation which concluded abuse occurred. They stated they had not contacted CRU or LLE because they were new to assisted living and unaware they were required to.

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)_____ .

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

_____ _____

Administrator (or Representative) Date