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) 45417 (Completion Date 08/12/2024) and 42001 (Completion Date 06/13/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 08/12/2024 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-2210-1-b

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 G
Residential Care Services

Residential Care Services
Investigation Summary Report

Provider/Facility: Brookdale Torbett
Provider Type: Assisted Living Facility
License/Cert.#: 2325
Compliance Determination #: 42001
Intake ID: 131882
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 05/31/2024 through 06/13/2024
Complainant Contact Date(s): 05/30/2024, 06/13/2024

Allegation(s):

1. Identified Resident is not receiving the medication services as ordered.
2. Residents are helping other residents when the staff is busy.

Investigation Methods:

Sample:	Total residents: 34 Resident sample size: 2 Closed records sample size: 1
Observations:	Residents Resident rooms Staff to resident interactions Resident to resident interactions Dining
Interviews:	Nursing staff Residents Family members
Record Reviews:	Medical records including negotiated service agreement, notes, medication administration records, Hospital records Facility policies

Investigation Summary:

1. Identified resident representative interview confirmed that the resident became constipated and required hospitalization. The facility staff interview confirmed that the resident orders were not transcribed correctly on admission. Facility record review showed that the resident did not receive their laxative as ordered and suffered from constipation. Failed practice identified. Please see the Statement of Deficiency dated 06/13/2024 for medication systems Washington Administrative Code 388-78a-2210.
2. Residents were clean and groomed, no observed injuries noted. Resident to resident interactions were observed to be pleasant. Staff to resident observations were observed to be meeting the care needs of residents. No failed practice identified.

Conclusion / Action:

☒ 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 # 42001
Plan of Correction	Brookdale Torbett	Completion Date
Page 1 of 3	Licensee: EMERITUS CORPORATION	06/13/2024

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 05/31/2024 and 05/31/2024 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 131882

The following sample was selected for review during the unannounced on-site visit: 2 of 34 current residents and 1 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.

Michelle Closner
Residential Care Services

06/14/2024
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 # 42001
Plan of Correction	Brookdale Torbett	Completion Date
Page 2 of 3	Licensee: EMERITUS CORPORATION	06/13/2024

Administrator (or Representative) — Date: 6/21/24

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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure a safe medication system was implemented for 1 of 3 residents (Resident 1) reviewed for medication services. These failures resulted in Resident 1 not receiving their medications as prescribed.

Findings included...

Review of the facility's policy titled, "Medication and Treatment Administration Assistance," revised on 03/31/2022, showed that medication assistance and administration would be in accordance with the prescriber's order. Staff would perform the checks to ensure that the right medication, and right dosage was given at the right time to the right resident by the right method prior to giving the medication.

Review of the facility's policy titled "Medication and Treatment-Storage, Handling, Disposition and Payment," dated 11/15/2015 showed that new physician/healthcare provider orders would be obtained by the facility and accepted into the community using a consistent procedure. The accepted medication would be immediately stored in accordance with their storage directions and by route of administration in the medication cart in preparation for medication delivery to the resident.

Review of Resident 1's Negotiated Service Agreement (NSA) dated 02/27/2024 showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnoses included [redacted].

Review of a Physician's Order dated 02/16/2024 at 3:45 PM showed that Resident 1 was to be given polyethylene glycol (medication for constipation) 17 grams in 4-8 ounces of water every day by mouth. The directions were to hold the medication if there were loose stools.

Administrator (or Representative) 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.

This requirement was not met as evidenced by:

Based on observation, interview, and record review, the Assisted Living Facility (ALF) failed to ensure a safe medication system was implemented for 1 of 3 residents (Resident 1) reviewed for medication services. These failures resulted in Resident 1 not receiving their medications as prescribed.

Findings included...

Review of the facility's policy titled, "Medication and Treatment Administration Assistance," revised on 03/31/2022, showed that medication assistance and administration would be in accordance with the prescriber's order. Staff would perform the checks to ensure that the right medication, and right dosage was given at the right time to the right resident by the right method prior to giving the medication.

Review of the facility's policy titled "Medication and Treatment-Storage, Handling, Disposition and Payment," dated 11/15/2015 showed that new physician/healthcare provider orders would be obtained by the facility and accepted into the community using a consistent procedure. The accepted medication would be immediately stored in accordance with their storage directions and by route of administration in the medication cart in preparation for medication delivery to the resident.

Review of Resident 1's Negotiated Service Agreement (NSA) dated 02/27/2024 showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnoses included [redacted].

Review of a Physician's Order dated 02/16/2024 at 3:45 PM showed that Resident 1 was to be given polyethylene glycol (medication for constipation) 17 grams in 4-8 ounces of water every day by mouth. The directions were to hold the medication if there were loose stools.

Review of Resident 1's March, April, and May 2024 Medication Administration Record (MAR) showed an order entered on 02/16/2023 that showed the resident was to receive polyethylene glycol 17 grams in 4-8 ounces of water every day by mouth as needed for constipation. The directions were to hold the medication if there were loose stools.

Review of Resident 1's medication list from their Primary Care Provider visit dated 02/16/2024 showed that Staff B, Medication Technician (MT) marked in the tracking area tool to show they had sent the orders and made a note in the progress notes. The rest of the order tracking tool was left blank including whether the MAR was reviewed. The fax cover sheet showed that the list was sent to the incorrectly listed PCP to confirm the medication order changes.

During an interview on 05/31/2024 at 3:52 PM, Staff A, Regional Nurse stated that the medication list order clarification sent to the doctor on 02/16/2024 should have had the tracking information section completed. They stated that staff would have then noticed the transcription error when doing the MAR review.

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) 7/26/24 .

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

Sarah McCallum — Administrator (or Representative)

6/21/24 — Date