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

12/25/2024

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) 51987 (Completion Date 12/25/2024) and 48034 (Completion Date 11/07/2024).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/25/2024 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

The Department staff who did the On Site verification:
Laurel Knight, Community Complaint Investigator

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, 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 #: 48034
Intake ID: 150522
Investigator: Laurel Knight
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 10/01/2024 through 11/07/2024
Complainant Contact Date(s): 10/11/2024, 11/06/2024

Allegation(s):
Identified resident has been neglected causing skin breakdown.

Investigation Methods:

Sample:	Total residents: 34 Resident sample size: 3 Closed records sample size: 0
Observations:	Identified resident Residents Staff to resident interactions Resident rooms
Interviews:	Identified resident Residents Nursing staff
Record Reviews:	Medical records including negotiated service agreement, notes, incident report and investigations.

Investigation Summary:
Identified resident was unable to recall any times where they did not receive care and services as agreed upon. The facility staff interview confirmed that the resident was left for over three hours without sheets on their bed and without any clothing. The facility investigation showed staff did not follow their normal process of going room to room during shift change due to staffing levels. Failed practice identified. Please see the Statement of Deficiency dated 11/07/2024 for citations related to Washington Administrative Code 388-78a-2660(1) and Revised Code of Washington 70.129.140 (1) related to resident rights and quality of life.

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 # 46034
Plan of Correction	Brookdale Torbett	Completion Date
Page 1 of 3	Licensee: EMERITUS CORPORATION	11/07/2024

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 10/01/2024 and 10/14/2024 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 149264, 150507, 150522

The following sample was selected for review during the unannounced on-site visit: 3 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 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.

J Salquist
Residential Care Services

11/14/2024
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.

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Residential Care Services

Date

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Statement of Deficiencies	License #: 2325	Compliance Determination # 48034
Plan of Correction	Brookdale Torbett	Completion Date
Page 2 of 3	Licensee: EMERITUS CORPORATION	11/07/2024

Administrator (or Representative) 11/22/24 Date

RCW 70.129.140 Quality of life -- Rights.

(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

WAC 388-78A-2660 Resident rights. The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

This requirement was not met as evidenced by:

Based on interview observation and record review, the Assisted Living Facility (ALF) failed to ensure a resident was treated with dignity and respect for 1 of 3 residents (Resident 1) who require assistance with their activities of daily living. This failure resulted in the resident being left with unmet needs and lying on a bare mattress for an extended period.

Findings included..,

Revised Code of Washington (RCW) 70.129.140 (1) (1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

Record review of Resident 1's ALF Negotiated Service agreement (NSA) dated 08/21/2024 showed that Resident 1 had a diagnosis of [redacted] and had a recent hip fracture. The healing fracture left Resident 1 unable to bear weight on the fracture side and their limited mobility left them at risk for skin breakdown on the backside of their body.

Record review of the facility Incident Report dated 10/16/2024 showed that Resident 1 had multiple incontinence episodes during the night and required a full bedding change at 5:00 AM. The report showed that staff did not follow their shift change process to do room to room report on the residents at 8:00 AM due to short staffing on night shift. Resident 1 was found at 8:30 AM lying on the bare mattress covered with only a bed pad under their bottom.

In an interview on 11/05/2024 at 10:30 AM, Collateral Contact 1 (CC1), stated that they observed Resident 1 in bed on 10/06/2024 at 8:30 AM. They stated that Resident 1 was wearing only a brief and had a cloth chair protector pad underneath their bottom. CC1

Administrator (or Representative) Date

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Statement of Deficiencies	License #: 2325	Compliance Determination # 48034
Plan of Correction	Brookdale Torbett	Completion Date
Page 3 of 3	Licensee: EMERITUS CORPORATION	11/07/2024

stated that there were no sheets on the bed or pillowcases on the pillows to protect the resident's skin from being in direct contact with the vinyl mattress. CC1 stated they were concerned that Resident 1's urinary catheter (tube inserted in the bladder) was not secured to their leg causing tension on the resident's penis.

In an interview on 11/06/2024 at 9:30 AM, Staff A, Administrator stated that staff on duty had not followed their usual procedure to check on residents in each room with the oncoming shift caused the delay in providing assistance to Resident 1.

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) 12-13-2024

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

Sarah McCollum 11/22/24

Administrator (or Representative) Date

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

_____ _____

Administrator (or Representative) Date