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) 36608 (Completion Date 02/09/2024) and 33187 (Completion Date 12/15/2023).

The Department completed a follow-up inspection of your Assisted Living Facility on 02/09/2024 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-2240, 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 #:** 33187
**Intake ID:** 107832
**Investigator:** Laurel Knight
**Region/Unit #:** RCS Region 1 / Unit G
**Investigation Date(s):** 11/30/2023 through 12/15/2023
**Complainant Contact Date(s):**

**Allegation(s):**

1. Identified residents were placed on a one to one for safety and the facility is not providing the staff.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 30<br>Resident sample size: 3<br>Closed records sample size: 0 |
| **Observations:** | Identified resident<br>Residents<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified resident<br>staff<br>Nursing staff<br>Family members |
| **Record Reviews:** | Medical records including negotiated service agreement, notes, medication administration records, incident report and investigations.<br>Staffing as worked schedules |

**Investigation Summary:**

1. Identified residents had assigned one on one staff on arrival but not throughout the visit. Facility staff interviews confirmed they were not always able to provide a one on one staff for both residents despite being agreed upon in the Negotiated service agreement. Deficient practice identified. Please see the Statement of Deficiency dated 12/15/2023 for WAC 388-78a-2160.

**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 #:** 33187
**Intake ID:** 107377
**Investigator:** Laurel Knight
**Region/Unit #:** RCS Region 1 / Unit G
**Investigation Date(s):** 11/30/2023 through 12/15/2023
**Complainant Contact Date(s):**

**Allegation(s):**
1. Identified resident missed their medications.

**Investigation Methods:**

**Sample:**
Total residents: 30
Resident sample size: 3
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.
State reporting log
Incident investigation
Facility policies

**Investigation Summary:**
1. The identified resident's representative stated the resident had a seizure from running out of their medication. Facility staff interview confirmed the resident missed three doses of their anti-seizure medication due to medication unavailability. Facility records showed the resident was sent to the emergency department for evaluation and treatment where they determined it was a seizure due to missed medication. Deficient practice was identified. See the Statement of Deficiency dated 12/15/2023 for WAC 388-78a-2240.

**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
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***1200 Alder Street, Union Gap, WA 98903***

| Statement of Deficiencies | License #: 2325 | Compliance Determination # 33187 |
|---|---|---|
| Plan of Correction | Brookdale Torbett | Completion Date |
| Page 1 of 5 | Licensee: EMERITUS CORPORATION | 12/15/2023 |

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 11/30/2023, 11/30/2023 and 12/13/2023 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 107832, 107377, 104858

The following sample was selected for review during the unannounced on-site visit: 3 of 30 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 — 12/20/2023

Residential Care Services — 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: 1.5.2024

**WAC 388-78A-2240 Nonavailability of medications. When the assisted living facility has assumed responsibility for obtaining a resident's prescribed medications, the assisted living facility must obtain them in a correct and timely manner.**

**This requirement was not met as evidenced by:**

Based on interview, and record review, the Assisted Living Facility (ALF) failed to ensure medications were available for 1 of 3 residents (Resident 1) reviewed for medication services. This failure resulted in Resident 1 having a seizure from not receiving their prescribed medications and placed other residents at risk for medication errors.

Findings included...

Review of the facility's policy titled, "Medication and Treatment -Storage, Handling, Distribution, Disposition and Payment" revised on 03/31/2022, showed that the community was responsible for obtaining refills for medication and treatment orders, unless otherwise agreed upon with the resident, family, or legally responsible party.

Review of Resident 1's assessments and negotiated service agreement dated 09/22/2023 showed that the facility managed and assisted Resident 1 with their medications. Resident 1's diagnoses included [redacted] and [redacted]

Review of the facility's Incident Report dated 11/15/2023 showed that Resident 1 had an order dated 10/10/2023 for levetiracetam (antiseizure medication) 500 milligrams (mg) by mouth twice daily.

Review of the November 2023 Medication Administration Record (MAR) showed that Resident 1 missed three doses of the levetiracetam, two doses on 11/19/2023 and one on 11/20/2023. Resident 1 also had an order dated 08/30/2023 for citalopram (dementia medication) 20 mg tablet by mouth once daily. Additionally, the November 2023 MAR showed Resident 1 missed their doses scheduled for 11/19/2023 and 11/20/2023. The documentation in the boxes on the MAR for the missed medications indicated there was an additional MAR note regarding the missed medications. The record did not contain additional notes supplied for review.

Review of the facility records showed a progress note dated 11/21/2023 at 0:05 by Staff C, Medication Technician (MT) charted that the facility had received Resident 1's medications.

The facility investigation dated 11/15/2023 completed by Staff A, Executive Director showed the facility sent a refill request to the pharmacy for the levetiracetam when the resident ran out of medications on 11/19/2023 causing them to miss their 8:00 AM and 5:00 PM doses as well as their 8:00 AM dose on 11/20/2023. Resident 1 fell and had seizure activity at 12:40 PM. The resident was sent to the emergency department for evaluation where they received medical treatment for their seizure.

During an interview on 12/05/2023 at 8:20 AM Resident 1's Representative Collateral Contact 1 (CC 1) stated that Resident 1 had run out of their antiseizure medication and had a seizure. CC1 stated that Resident 1 had not had any seizures recently and could not understand how the facility could run out of medication. They stated that the lack of medication caused Resident 1 to have the seizure and caused them an unnecessary trip to the emergency department. CC1 stated that the resident had to have medications at the hospital to stop the seizure and a dose of levetiracetam due to the missed doses.

During an interview on 11/30/2023 at 11:10 AM Staff B, Medication Technician (MT) stated that they noticed that Resident 1 missed their doses 11/19/2023 and they reached out to the pharmacy on 11/20/2023 to send the signed request for a refill for the citalopram and the levetiracetam. Staff B stated that the pharmacy said due to the lateness of the day, the medication would not arrive until the next day. Staff B stated, "I think we could have done better with the reordering."

This is a recurring deficiency previously cited on 06/15/2022.

**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) 1.26.2024

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

[signature], ED — Administrator (or Representative)

1.5.2024 — 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 ensure residents were receiving the care and services agreed upon in their Negotiated Service Agreement (NSA) for 1 of 2 residents (Resident 2) reviewed for one to one supervision. This failure left residents at risk of incidents and altercations while not closely supervised.

Findings included...

Review of Resident 2"s NSA dated 11/09/2023 showed that the facility managed and assisted Resident 2 with their activities of daily living and behavior management. Resident 2 had noted sexual behaviors toward another resident and a one to one monitoring was put in place for safety.

Resident 2 was observed in the facility on 11/30/2023 at 2:30 PM without a one-on-one staff member.

Review of the facility's staffing schedule for the one to ones dated 11/08/2023 through 11/30/2023 showed that there was combined coverage for both residents by one staff member each night from 10:00 PM thru 6:00 AM for the 23 days. These scheduled combined one to one coverage by one staff would not meet a one-on-one supervision as both residents lived on opposite wings of the facility. The record showed there were three shifts that were not covered by any staff for 6:00 AM to 2:00 PM on 11/13/2023, 11/28/2023 and 11/29/2023. There were three shifts not covered by staff for 2:00 PM to 10:00 PM on 11/17/2023, 11/23/2023 and 11/28/2023.

Review of the facility records showed a progress note dated 11/12/2023 at 6:35 PM by Staff C, Medication Technician (MT) charted that Resident 2 was the alleged victim in a resident-to-resident altercation while sitting outside of their room. The residents were pushing at each other and then Resident 2 was hit in the face before staff had to intervene.

During an interview on 12/15/2023 at 11:49 AM Resident 2's representative Collateral Contact 1 (CC 1) stated that to their knowledge Resident 2 had a one to one in place as agreed upon until they discussed the one to one being discontinued.

During an interview on 12/13/2023 at 7:50 AM with Staff A, Executive Director stated that sometimes there were holes in the schedule and there was no one available to provide one to one monitoring. They stated that the facility plan was to have Resident 2 in the line of sight while the caregiver assigned to the wing was in the room providing resident care to other residents after 10:00 PM. When the Complaint Investigator asked how one staff member could provide one to one coverage for two residents at a time in separate wings Staff A stated that the plan was not to have a dedicated one to one for Resident 2 because generally they slept.

**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) 1.26.2024 .

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

Julia [illegible], ED
Administrator (or Representative)

1.5.2024
Date

Gwin Kaercher
Residential Care Services Region 1, Unit G
1200 Alder St
Union Gap, WA 98903

1/5/2024

*The following is the Plan of Correction for Brookdale Torbett regarding the Statement of Deficiencies dated 12/15/2023. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is a submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.*

*Deficiency #1: WAC 388-7A-2240 Nonavailability of Medications*

***(Resident 1)***

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; (Resident 1) has medications currently in place.

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken; HWD or designee reviewed the medication records for other residents receiving medication assistance to confirm that their medications were present. No other residents were affected by the deficient practice. Executive Director (ED), Health & Wellness Director (HWD) or Designee to in-service the Medication Technicians on Brookdale Medication Policy and Procedure: *Medications and Treatments-Availability CS-40-3*. ED, HWD or Designee to review Clinical Meeting Checklist daily and EMAR dashboard review. *Medication Passer PCC Workflow for Success* implemented and utilized upon med-cart pass-off. Completion date 1/26/24

Element 3. Who is responsible for the corrective action; ED or Designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance) ED, HWD or Designee to review Clinical Meeting Checklist and EMAR review of dashboard daily.

Element 5. Date by which the correction will be made. 1/26/24

*Deficiency #2: WAC 388-7A-2160 Implementation of Negotiated Service Agreement*

***(Resident 2)***

Element 1. What corrective actions will be taken for those residents found to have been affected by the alleged deficient practice; Resident 2 no longer requires one-to-one supervision. (Resident 2)

Negotiated Service Assessment (NSA) and Negotiated Service Plan (NSP) were updated on 12/18/23 to reflect current care needs.

Element 2. How the Community will identify other residents with the potential of being affected by the alleged deficient practice and what corrective action will be taken; No other residents have been identified as needing one-to-one supervision so no other residents were affected by the deficient practice. The ED, HWD or Designee will discuss change of conditions in Clinical Meeting and will update a resident's NSA and NSP as needed. Care team will be re-educated on *COC CS 20-1 Policy* and *Service Plan Process CS-70-3 Policy*. Completion date 1/26/24

Element 3. Who is responsible for the corrective action; ED or Designee

Element 4. How the corrective measures will be monitored to prevent the recurrence of the alleged deficiency (Quality Assurance) ED, HWD or Designee will review and/or discuss Clinical Meeting Checklist and NSA changes in the in Collaborative Care Review monthly.

Element 5. Date by which the correction will be made. 1/26/24

, ED

Tula Jackson, Executive Director

Brookdale Torbett