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

03/24/2025

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) 56751 (Completion Date 03/24/2025) and 52160 (Completion Date 01/21/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/24/2025 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
WAC 388-78A-2610 Infection control.

(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.

(2) The assisted living facility must:

(a) Develop and implement a system to identify and manage infections;

(b) Restrict a staff person's contact with residents when the staff person has a known communicable disease in the infectious stage that is likely to be spread in the assisted living facility setting or by casual contact;

(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

The Department staff who did the On Site verification:

Elizabeth Hall, AFH/ALF Licensor
Robin Rainville, Assisted Living Facility Licensor

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

Sincerely,

Laura Williams-Davis

Laura Williams-Davis, ALF 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 #: 52160
Intake ID: 160785
Investigator: Elizabeth Hall
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 12/30/2024 through 01/21/2025
Complainant Contact Date(s):

Allegation(s):
The facility had an outbreak of norovirus (a highly contagious stomach virus that caused nausea, vomiting and diarrhea).

Investigation Methods:

Sample:
Total residents: 45
Resident sample size: 6
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Resident to resident interactions
Kitchen
Food preparation

Interviews:
Identified resident
Residents
Nursing staff
Family members
Housekeeping staff
Kitchen staff
Laundry staff
Administrator

Record Reviews:
Medical records
Hospital records
Incident investigation
Facility policies
Staff training records
Staff patterns
Resident characteristic roster
Facility policies
State reporting log

Investigation Summary:

Observation interview and record review showed that the failed to implement and manage appropriate infection control practices and to provide the necessary supplies to care for residents. Additionally, the facility failed to provide staff with the necessary training and protection needed to prevent the spread of infections. Twenty four residents and fifteen staff developed symptoms of norovirus. The facility also developed an outbreak of COVID-19 during the course of the investigation. Failed practice identified on the Statement of Deficiencies dated 01/21/2024 for Washington Administrative Code 388-78a-2610(1)(2)(a)(b)(d)(e).

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 12/30/2024 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 159479, 160785

The following sample was selected for review during the unannounced on-site visit: 6 of 45 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Elizabeth Hall, AFH/ALF Licensor
Robin Rainville, Assisted Living Facility Licensor

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 1 , Unit G
1200 Alder Street
Union Gap, WA 98903

Statement of Deficiencies	License #: 2325	Compliance Determination # 52160
Plan of Correction	Brookdale Torbett	Completion Date
Page 2 of 8	Licensee: EMERITUS CORPORATION	01/21/2025

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.

Laura Williams-Davis — Residential Care Services

01/30/2025 — 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.

Sarah McCallum — Administrator (or Representative)

01/31/25 — Date

WAC 388-78A-2610 Infection control.

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(c) Provide staff persons with the necessary supplies, equipment and protective clothing for preventing and controlling the spread of infections;

(d) Provide all resident care and services according to current acceptable standards for infection control;

(e) Perform all housekeeping, cleaning, laundry, and management of infectious waste according to current acceptable standards for infection control;

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to implement and manage appropriate infection control practices and to provide the necessary supplies to care for residents, for 6 of 6 residents (Residents 1, 2, 3, 4, 5 and 6). Additionally, the facility failed to provide staff with the necessary training and protection needed to prevent the spread of infections for 7 of 9 staff (Staff B, F, G, H, I, J, and K). These failures contributed to the spread of two infectious diseases throughout the facility and placed the residents at risk of complications of the illnesses and a decreased quality of life.

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.

Laura Williams-Davis
Residential Care Services

01/30/2025
Date

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Administrator (or Representative)

Date

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This requirement was not met as evidenced by:

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Findings included...

Review of a facility policy titled, "Communicable Disease Control," dated 04/2024, showed that if an outbreak of a communicable disease occurred within the facility, staff were to adhere to standard precautions and the use of Personal Protective Equipment (PPE- gloves, gowns, masks, etc). The policy showed that standard precautions would be exercised during resident care, including the handling of any personal resident items.

Review of an additional facility policy titled, "PPE Use Policy," dated 11/2022, showed that in the case of a norovirus (the virus that is the most common cause of stomach Infection, characterized by non-bloody diarrhea, vomiting, stomach pain, fever and/or headaches) outbreak, staff were to use contact based precautions which would include the use of gowns, masks, face shields, and gloves, when caring for symptomatic residents. The policy showed that in the event of respiratory illness outbreaks including COVID-19, n95 respirator masks (special protective masks that filter out harmful substances and require training and testing to ensure proper fit and protection for the wearer) were required to be used when caring for symptomatic residents.

Review of the facility's norovirus tracking list, titled, "GI [Gastrointestinal] Line List," showed that between 12/22/2024 and 01/08/2025, a total of 24 residents and 15 staff had developed norovirus symptoms. The list showed that two staff members presented the first cases of symptoms, then the resident symptoms started on 12/24/2024 with 13 cases. The list showed that Residents 1, 2, 3, 4, 5 and 6 were included in the list as having had norovirus symptoms.

Resident 1

Review of the facility's norovirus symptom tracking sheet showed that Resident 1 developed the norovirus symptoms on 12/28/2024, which resolved on 12/29/2024.

Review of a Temporary Service Plan (TSP) in Resident 1' s record, dated 01/09/2024, showed that the resident was positive for COVID-19.

Resident 1's progress notes, dated 12/13/2024 through 01/10/2025, did not show documentation regarding the resident's norovirus symptoms. Resident 1's progress notes, dated 01/10/2025, showed that the resident was on alert charting due to testing positive for COVID-19.

Resident 2

Review of the facility's norovirus symptom tracking sheet showed that Resident 2 developed the virus symptoms on 12/24/2025.

Review of progress notes in Resident 2's record, dated 12/24/2024 through 12/30/2024, showed that the resident had been monitored for viral symptoms of nausea, vomiting and diarrhea.

Review of a TSP in Resident 2' s record, dated 12/30/2024, showed that the resident had new orders for medications to reduce vomiting and diarrhea.

Resident 3

Review of the facility's norovirus symptom tracking sheet showed that Resident 3 developed the norovirus symptoms on 12/24/2025, which resolved on 12/28/2024.

Review of progress notes in Resident 3's record, dated 12/27/2024, showed that the resident had medication changes due to having diarrhea that had started on 12/24/2024.

Resident 4

Review of the facility's norovirus symptom tracking sheet showed that Resident 4 developed the virus symptoms on 12/24/2025. The tracking sheet showed that Resident 4 had a confirmed diagnosis of [redacted].

Review of progress notes in Resident 4's record, dated 12/25/2024, showed that the resident was seen in the ER due to vomiting and diarrhea. Resident 4 returned from the ER with a diagnosis of a [redacted].

Resident 5

Review of the facility's norovirus symptom tracking sheet showed that Resident 5 developed the norovirus symptoms on 12/27/2024.

Review of progress notes in Resident 5's record, dated 12/27/2024, showed that the resident had nausea and vomiting. The notes showed that Resident 5 was unable to take their medications due to vomiting and diarrhea. Additionally, Resident 5's progress notes, dated 01/05/2024, showed that the resident tested positive for COVID-19.

Review of a TSP in Resident 5' s record, dated 01/05/2024, showed that the resident was positive for COVID-19.

Resident 6

Review of the facility's norovirus symptom tracking sheet showed that Resident 6 developed the virus symptoms on 12/24/2025.

Review of progress notes in Resident 6's record, dated 12/25/2024, showed that the resident had diarrhea and vomiting. The notes showed that Resident 6 was unable to take their medications due to persistent vomiting.

Observation on 12/30/2024 at 11:04 AM showed that there were caution signs on the facility's entry and hall doors notifying visitors that the facility had an infectious outbreak. Also observed were boxes of n95 respirators and surgical masks on the counter in the entrance, as well as jars for clean pens and dirty pens to be used when signing into the facility.

In an interview on 12/30/2024 at 11:04 AM, Staff E, Business Office Manager, stated that the facility was experiencing a norovirus outbreak. Staff E stated that Staff A, Administrator, was out of the facility due to being sick with the virus.

In an Interview on 12/30/2024 at 11:10 AM, Staff B, Licensed Practical Nurse, stated that they had been told there was a norovirus outbreak in the facility. Staff B stated that they were told that the outbreak started on 12/23/2024 on the 100s hall first then spread to the 200s hall. Staff B stated that Staff A had worked as a caregiver due to care staff being sick. Staff B stated that one resident case was confirmed as norovirus and all others were being treated as such due to the similarity in symptoms. Additionally, Staff B stated that the facility was utilizing hand hygiene, isolation of residents as able, and dedicated medical equipment for ill residents, to prevent spread of the virus. Finally, Staff B stated that care staff were only working in the hall they were assigned to, to prevent the spread of illness between the 100 and 200 sides of the facility.

Observation on 12/30/2024 at 11:17 AM showed Staff F, Caregiver, walking down hall to room [redacted]. A sign on the door indicated contact precautions which required the use of PPE including disposable gowns, gloves and masks were to be worn before entering the room. There was no PPE observed near the room and the door was open. Staff F wore gloves and no gown when they entered the resident room. Staff F exited the room with the resident and escorted the resident to the dining room. Observation on 12/30/2024 at 11:18 AM showed that Staff F then escorted a second resident to the dining room and to the same table where the first resident was seated. Staff F was not observed to perform hand hygiene or change gloves after escorting either resident.

In an interview on 12/30/2024 at 11:19 AM, Staff F stated that they had not received

any direction on PPE use or cleaning the environment. Staff F stated that they were doing their best to take out the garbage when it was full and take the laundry to the laundry room when it was full. Staff F stated that they were working short staffed and cleaning up residents was their priority. Staff F did not know the facility policy on staff illness or return to work. Additionally, Staff F stated that they did not think the facility kept PPE supplies near the rooms of symptomatic residents.

Observation on 12/30/2024 at 11:20 AM showed Staff H, Caregiver, coming out of a resident bathroom, still wearing disposable gloves. Staff H was then observed to assist a resident to pull up their pants which had started to fall down as they walked down the hallway. Staff F was not observed to perform hand hygiene or change gloves before or after helping the resident.

In an interview on 12/30/2024 at 11:21 AM, Staff H stated that most of the residents on the 100s side had been ill with norovirus. Staff H stated that they had just come back to work after being off for two days due being ill from the virus. Staff H stated the facility had not told them to wear a mask or what precautions to take in regard to the current outbreak in the facility. Staff H stated that they should probably wear a mask.

In an interview on 12/30/2024 at 11:25 AM, Collateral Contact 1 (CC 1), family member of an unnamed resident, stated that they had come to the facility on 12/24/2024 and saw that there were seven ambulances in front of the facility. CC 1 stated that later that night, the facility called CC 1 to notify them that the unnamed resident had started vomiting.

Observation on 12/30/2024 at 11:33 AM showed that Resident 3's room had a contact precaution sign posted on the resident's door. The sign indicated that PPE including disposable gowns, gloves and masks were required to be worn before entering the room. There was no PPE observed near the room, the door was open, and there was no closed garbage can inside the room to dispose of used PPE.

Observation on 12/30/2024 at 11:33 AM showed Staff G, Medication Technician, exited the 100 side of the facility and entered the 200 side. Staff G then entered the laundry room through the door indicating it was the soiled entrance, which contained 16 baskets of dirty laundry stacked on top of each other. The side of the laundry room labeled as the clean side had multiple baskets of laundry. A cart used for transporting clean laundry in the clean side of the laundry room was full of loose unbagged laundry items with a handwritten sign on top that read, "Dirty."

In an interview on 12/30/2024 at 11:35 AM, Staff G stated that the facility had not been keeping PPE supplies outside the rooms of residents who had the norovirus to have PPE accessible easily, and that there were no garbage cans in the residents' rooms to dispose of used PPE. Staff G stated that at one point during the outbreak they had sent a caregiver home who vomited at work. Staff G stated that they had received no training on norovirus since the outbreak had started. Staff G stated the activity staff

members had stepped up to work in the kitchen due to kitchen staff being out sick. Additionally, Staff G stated that the baskets of laundry observed in the clean and soiled laundry rooms contained dirty laundry, and that the staff could not keep up with the amount of dirty laundry that was piling up due to the outbreak.

Review of the facility's characteristic roster, undated, showed that Residents 2, 4, and 6 lived on the 100s side of the facility. The roster showed that Residents 1, 3 and 5 lived on the 200s side of the facility.

Observation on 12/30/2024 at 11:59 AM showed that Resident 1 was seated on the couch in the living room on the 200s side of the facility.

Observation on 12/30/2024 at 12:02 PM showed that residents were seated closely at the dining tables eating lunch.

Observation on 12/30/2024 at 12:04 PM showed an unnamed resident rifling through a stack of PPE supplies on the counter of the dinette on the 200s side of the facility. Additionally Resident 3 was observed to be seated in the dining room with three other residents at the same table.

Staff

Review of the facility's norovirus symptom tracking sheet showed that Staff K, Caregiver, had symptoms of the norovirus from 12/22/2024 through 12/25/2024.

Review of the facility's as worked staff schedule for December 2024, showed that Staff K worked in the facility on 12/22/2024, 12/23/2024 and 12/24/2024.

Review of the facility's staff training in-services records showed that staff were not trained on proper PPE use, hand sanitizing, and cleaning protocols until 12/30/2024 at 4:30 PM. The in-services showed that staff were trained on the facility's infection control policies on 12/31/2024, at an unknown time.

Review of staff training records showed that the following staff did not have documentation to show that they had been trained and fit tested for the use of n95 respirator masks:

Staff B, Licensed Practical Nurse
Staff F, Caregiver
Staff G, Medication Technician
Staff H, Caregiver

Staff I, Caregiver
Staff J, Medication Technician
Staff K, Caregiver

In an interview on 1/21/2025 at 10:41 AM, Staff A stated that the facility had gotten n95 fit testing and training done for only a few staff members. Staff A acknowledged that Staff B, F, H, I, J and K had not been fit tested.

In an interview on 12/30/2024 at 2:22 PM, Collateral Contact 2 (CC 2), Registered Nurse with the local health jurisdiction, stated that the facility reported the outbreak to CC 2's department on 12/27/2024. CC 2 stated that they had made an initial visit on that same day and found the facility was not using the proper cleaning products.

In an interview on 01/10/2025 at 9:33 AM, CC 2 stated that CC 2 went onsite for a second visit to the facility in the afternoon of 12/30/2024. CC 2 stated that they had identified the facility had infection control failures, a lack of signage, lack of PPE carts and use, and staff were not using proper cleaning practices. CC 2 stated that Staff B had developed the norovirus as well, and that Staff B worked at the facility's sister location, which had also since developed a norovirus outbreak. CC 2 stated that it was obvious that there was a lack of training of the facility staff on infection prevention and how to handle infectious outbreaks. Finally, CC 2 stated that the facility was now in the midst of another outbreak, of COVID-19.

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) Feb. 28, 2025

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

Sarah McCallum — Administrator (or Representative)

2/6/25 — Date

Staff I, Caregiver
Staff J, Medication Technician
Staff K, Caregiver

In an interview on 1/21/2025 at 10:41 AM, Staff A stated that the facility had gotten n95 fit testing and training done for only a few staff members. Staff A acknowledged that Staff B, F, H, I, J and K had not been fit tested.

In an interview on 12/30/2024 at 2:22 PM, Collateral Contact 2 (CC 2), Registered Nurse with the local health jurisdiction, stated that the facility reported the outbreak to CC 2's department on 12/27/2024. CC 2 stated that they had made an initial visit on that same day and found the facility was not using the proper cleaning products.

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Administrator (or Representative) Date