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) 57983 (Completion Date 04/15/2025) and 54310 (Completion Date 02/19/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/15/2025 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

The Department staff who did the on-site verification:
Robin Barnes, 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 #: 54310
Intake ID: 164890
Investigator: Elizabeth Hall
Region/Unit #: RCS Region 1 / Unit G
Investigation Date(s): 02/07/2025 through 02/19/2025
Complainant Contact Date(s):

Allegation(s):
Four named residents missed doses of medications.

Investigation Methods:

Sample:
Total residents: 44
Resident sample size: 4
Closed records sample size: 0

Observations:
Identified resident
Residents
Activities
Dining
Resident rooms
Staff to resident interactions
Medication administration
General facility environment
Medication room

Interviews:
Medication Technicians
Administrator
Director of Nursing
Pharmacist

Record Reviews:
Characteristic roster
Medical records (care plans, progress notes, medication administration records (MARs), physician orders
Facility policies
Staff training records
Staff patterns/schedules/list

Investigation Summary:
Interview and record review showed that three of the named residents missed multiple consecutive doses of various medications. The facility failed to ensure residents received medications as prescribed, when the facility had assumed responsibility for obtaining residents' medications. Failed practice identified under WAC 388-78a-2240 Nonavailability of medication.

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 02/07/2025 of:

Brookdale Torbett
221 Torbett St
Richland, WA 99354

This document references the following complaint number(s): 164890

The following sample was selected for review during the unannounced on-site visit: 4 of 44 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 # 54310
Plan of Correction	Brookdale Torbett	Completion Date
Page 2 of 5	Licensee: EMERITUS CORPORATION	02/19/2025

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

03/03/2025
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.

Administrator (or Representative)

3/11/2025
Date

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 facility failed to ensure medications were available for 3 of 4 residents (Resident 1, 2, and 3). This failure resulted in 3 residents not receiving medications, contributed to Resident 2 exhibiting agitation and placed the residents at risk for a decline in their chronic health conditions.

Findings included...

Review of a facility policy titled, "Medications & Treatments- Medication Error," revised 07/2023, showed that if a resident missed a dose of medication, that would be considered a medication error.

In an interview on 02/07/2025 at 11:31 AM, Staff A, Registered Nurse/Health and Wellness Director, stated that the procedure for reordering residents' medication was for the Medication Technician (MT) to do so when the supply was down to about five to seven days remaining. Staff A stated that if the medication was not on a routine auto refill process the MT would call the pharmacy. If the pharmacy identified the medication order was out of refills, the MT would call or fax the resident's doctor for a new order.

<Resident 2>

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

03/03/2025
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.

Administrator (or Representative)

Date

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 facility failed to ensure medications were available for 3 of 4 residents (Resident 1, 2, and 3). This failure resulted in 3 residents not receiving medications, contributed to Resident 2 exhibiting agitation and placed the residents at risk for a decline in their chronic health conditions.

Findings included...

Review of a facility policy titled, "Medications & Treatments- Medication Error," revised 07/2023, showed that if a resident missed a dose of medication, that would be considered a medication error.

In an interview on 02/07/2025 at 11:31 AM, Staff A, Registered Nurse/Health and Wellness Director, stated that the procedure for reordering residents' medication was for the Medication Technician (MT) to do so when the supply was down to about five to seven days remaining. Staff A stated that if the medication was not on a routine auto refill process the MT would call the pharmacy. If the pharmacy identified the medication order was out of refills, the MT would call or fax the resident's doctor for a new order.

<Resident 2>

Review of Resident 2's Negotiated Service Agreement (NSA), updated 01/29/2025, showed that the resident required staff to order their medication through the facility's house pharmacy. The NSA showed that Resident 2 required staff to administer their medication under nurse delegation. The NSA showed that Resident 2 required pain medication and a medication to stabilize moods. Additionally, the NSA showed that unwanted behaviors and agitation could be caused by Resident 2 having pain or discomfort.

Review of Resident 2's progress notes, dated 12/13/2024, showed that Resident 2's doctor saw them at the facility due to needing refills of their Tramadol (narcotic pain medication).

Review of Resident 2's January 2025 Medication Administration Record (MAR) showed that between 01/02/2025 and 01/08/2025, the resident did not receive 13 doses of Tramadol. Additionally, the MAR showed that Resident 2 had increased agitation and was given their Lorazepam (a mood stabilizing medication) on 01/07/2025, 01/08/2025, 01/09/2025 and 01/10/2025.

Review of Resident 2's progress notes dated between 01/02/2025 and 01/08/2025 showed that the reasons the resident did not receive their Tramadol included, "awaiting medication arrival," "medication not in cart," and "resident is out of medication." Additionally, Resident 2's progress note, dated 01/27/2025, showed that Resident 2's doctor saw the resident at the facility due to needing refills of their Tramadol.

Review of Resident 2's February 2025 MAR showed that between 02/08/2025 and 02/10/2025, the resident missed five doses of their Tramadol. Additionally, the MAR showed that Resident 2 had increased agitation and was given their Lorazepam on 02/10/2025.

Review of Resident 2's progress notes dated between 02/08/2025 and 02/10/2025 showed that the reasons the resident did not receive their Tramadol included, "waiting on med[ication]" and "awaiting order."

In an interview on 02/19/2025 at 1:05 PM, Collateral Contact 1 (CC1), Pharmacist, stated that Resident 2 could likely exhibit signs of withdrawal from not receiving Tramadol. CC1 stated that Resident 2's signs of withdrawal could include confusion, disorientation and anxiety, especially considering the resident's diagnosis of [redacted].

<Resident 1>

Review of Resident 1's NSA, updated 12/10/2024, showed that the resident required staff to order their medication through their preferred pharmacy. The NSA showed that Resident 1 required staff assistance with medication administration.

Review of Resident 1's December 2024 MAR showed that between 12/13/2024 and 12/23/2024, the resident did not receive six doses of atorvastatin (to lower cholesterol).

Review of Resident 1's progress notes from 12/13/2024 through 12/20/2024 showed that the reasons the resident did not receive their atorvastatin included, "awaiting refill," "will refax [doctor]," and "awaiting [doctor] order."

Review of Resident 1's January 2025 MAR showed that between 01/23/2025 and 01/31/2025, the resident did not receive eight doses of their atorvastatin.

Review of Resident 1's progress notes from 01/23/2025 through 01/31/2025 showed that the reasons the resident did not receive their atorvastatin included, "awaiting medication arrival," "not in cart," and "awaiting medication refill."

Review of Resident 1's February 2025 MAR showed that between 02/01/2025 and 02/03/2025, the resident missed three doses of atorvastatin.

Review of Resident 1's progress notes dated between 02/01/2025 and 02/03/2025 showed that the reasons the resident did not receive their atorvastatin included, "awaiting medication arrival." Resident 1's progress notes dated 02/03/2025 showed that Resident 1 did not have any atorvastatin. The note showed that the facility nurse had been notified.

<Resident 3>

Review of Resident 3's NSA, updated 10/09/2024, showed that the resident required the facility to order their medication through the facility's house pharmacy. The NSA showed that Resident 3 required staff to assist with medication administration. Additionally, the NSA showed that Resident 3 took pain medication and a medication to manage behaviors.

Review of Resident 3's December 2024 and January 2025 MARs showed that between 12/14/2024 and 01/14/2025, the resident did not receive 27 doses of Seroquel (a medication used to manage certain mental/mood disorders).

Review of Resident 3's progress notes from 12/14/2024 through 01/14/2025 showed that the reasons the resident did not receive their Seroquel included, "waiting on order," "resident is out of medication," and "medication not in cart."

Statement of Deficiencies	License #: 2325	Compliance Determination # 54310
Plan of Correction	Brookdale Torbett	Completion Date
Page 5 of 5	Licensee: EMERITUS CORPORATION	02/10/2025

Review of Resident 3's December 2024, January 2025 and February 2025 MARs showed that between 12/23/2024 and 02/09/2025, the resident did not receive 17 doses of Zolpidem tartrate (a medication used to manage sleep disorders).

Review of Resident 3's progress notes from 12/23/2024 through 01/08/2025 showed that the reasons the resident did not receive their Zolpidem tartrate included, "medication not in cart," "waiting on order," and "not found in med[ication] cart."

In an interview on 02/11/2025 at 3:08 PM, Staff A stated that they were not aware of Residents 1, 2 and 3's missed medication doses and did not know why the medications were not available.

In an interview on 02/12/2205 at 10:51 AM, Staff A stated that the facility staff failed to follow up on Residents 1, 2 and 3's medication refills when they were needed.

This is a recurring citation previously cited on the Statement of Deficiencies dated 6/15/2022 for Washington Administrative Code (WAC) 388-78a-2240, and on the Statement of Deficiencies dated 12/15/2023 for WAC 388-78a-2240.

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) APRIL 14, 2025

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

Administrator (or Representative) Sarah McCallum Date 3/11/25

Review of Resident 3's December 2024, January 2025 and February 2025 MARs showed that between 12/23/2024 and 02/09/2025, the resident did not receive 17 doses of Zolpidem tartrate (a medication used to manage sleep disorders).

Review of Resident 3's progress notes from 12/23/2024 through 01/08/2025 showed that the reasons the resident did not receive their Zolpidem tartrate included, "medication not in cart," "waiting on order," and "not found in med[ication] cart."

In an interview on 02/11/2025 at 3:08 PM, Staff A stated that they were not aware of Residents 1, 2 and 3's missed medication doses and did not know why the medications were not available.

In an interview on 02/12/2205 at 10:51 AM, Staff A stated that the facility staff failed to follow up on Residents 1, 2 and 3's medication refills when they were needed.

This is a recurring citation previously cited on the Statement of Deficiencies dated 6/15/2022 for Washington Administrative Code (WAC) 388-78a-2240, and on the Statement of Deficiencies dated 12/15/2023 for WAC 388-78a-2240.

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