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

Colonial Vista Community Healthcare, LLC
Colonial Vista Senior Living
601 OKANOGAN AVE
WENATCHEE, WA 98801

RE: Colonial Vista Senior Living License # 2712

Dear Administrator:

This letter addresses Compliance Determination(s) 70898 (Completion Date 01/16/2026) and 65207 (Completion Date 11/13/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/16/2026 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-2730-1-a, WAC 388-78A-2730-1-b, WAC 388-78A-2650-2, WAC 388-78A-2650-3

The Department staff who did the on-site verification:
Nicole Mcgraw, Community Complaint Investigator

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: Colonial Vista Senior Living **Provider Type:** Assisted Living Facility

License/Cert.#: 2712
Intake ID: 193470
Compliance Determination #: 65207
Region/Unit #: RCS Region 1 / Unit G
Investigator: Nicole Mcgraw
Investigation Date(s): 09/05/2025 through 11/13/2025
Complainant Contact Date(s): 09/09/2025

Allegation(s):
The facility had a bacteria in their water and failed to follow the order of the Local Health Jurisdiction.

Investigation Methods:

Sample:	Total residents: 25 Resident sample size: 24 Closed records sample size: 1
Observations:	Environment, Apartments
Interviews:	Staff and others not associated with the facility.
Record Reviews:	Characteristic roster, Facility policies, Local Health Jurisdiction Reports, Resident Records, Facility incident investigation and documentation.

Investigation Summary:
Observation, interview and record review showed the facility failed to implement the recommendations from the Local Health Jurisdiction (LHJ) when the facility had the facility water contaminated with a bacteria. Failed Practice Identified, Washington Administrative Code (WAC) 388-78A-2650(2)(3) and WAC 388-78A-2730(1)(a)(b) reference Statement of Deficiencies dated 11/13/2025.

Conclusion / Action:

- [x] Failed Provider Practice Identified / Citation(s) Written
- [ ] Failed Provider Practice Not Identified / No Citation Written
- [ ] N/A

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AGING AND LONG-TERM SUPPORT ADMINISTRATION
1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2712	Compliance Determination # 65207
Plan of Correction	Colonial Vista Senior Living	Completion Date
Page 1 of 10	Licensee: Colonial Vista Community Healthcare, LLC	11/13/2025

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 09/05/2025, 09/17/2025 and 09/25/2025 of:

Colonial Vista Senior Living
601 OKANOGAN AVE
WENATCHEE, WA 98801

This document references the following complaint number(s): 193470

The following sample was selected for review during the unannounced on-site visit: 24 of 25 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Nicole Mcgraw, 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.

Laura Williams-Davis — 11/21/2025

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.

Brooke Capps — 12/2/25

Administrator (or Representative) — Date

WAC 388-78A-2730 Licensee's responsibilities.

(1) The assisted living facility licensee is responsible for:

(a) The operation of the assisted living facility;

(b) Complying at all times with the requirements of this chapter, chapter 18.20 RCW, and other applicable laws and rules; and

This requirement was not met as evidenced by:

Based on observation, interview and record review, the assisted living facility failed to implement immediate control measures when the facilities water tested positive for Legionella, and a resident was hospitalized and tested positive for Legionella for 1 of 1 resident (Resident 1). This failure resulted in an imminent health hazard to residents and a delay in the implementation of immediate control measures and also contributed to Resident 1 having worsening health complications, multiple hospitalizations and placed residents at risk of exposure to bacteria in the water.

Findings included...

Review of RCW 18.20.090 The department shall adopt, amend, and promulgate such rules, regulations, and standards with respect to all assisted living facilities and operators thereof to be licensed hereunder as may be designed to further the accomplishment of the purposes of this chapter in promoting safe and adequate care of individuals in assisted living facilities and the sanitary, hygienic and safe conditions of the assisted living facility in the interest of public health, safety, and welfare.

Review of the undated Characteristic Roster showed the facility was providing cares and services for 24 residents.

<Resident 1>

Review of Resident 1's hospital records dated [redacted]/2025, showed a positive rest result for (a bacteria that causes a lung infection when a person breathes in contaminated water droplets).

Review of Resident 1's hospital records showed the resident was hospitalized for Legionella pneumonia from [redacted]/2025 to [redacted]/2025. The resident was hypoxic (low oxygen levels) that required them to use oxygen, and their chest x-ray showed that they had abnormalities indicative of a lung infection.

Review of Resident 1's hospital records showed the resident was hospitalized [redacted]/2025 through [redacted]/2025. The resident presented to the hospital with a productive cough of bloody sputum, shortness of breath, chest tightness, abnormal lung sounds and low oxygen levels. The records showed that resident was diagnosed with [redacted] that resulted from the resident having a Legionella infection in May 2025. The resident required continuous oxygen to maintain oxygen levels in normal range and was discharged home requiring continuous use of oxygen.

Review of Resident 1's hospital records showed the resident was hospitalized for recurrent respiratory failure from low levels of oxygen in the body's tissue, [redacted]/2025 through [redacted]/2025. The notes showed that the resident had been on 3 liters of oxygen at the facility and required increased oxygen and a specialty oxygen mask to get the resident's oxygen levels up. The resident had episode of oxygen levels dropping to 53% (normal is 90-100%) while at the facility, prior to going to the hospital. Further review of the hospital record notes the resident was having headaches due to the low oxygen levels. The record showed that resident had abnormal lung sounds and difficulty breathing. The chest x-ray showed that it was abnormal, suggesting pneumonia (lung infection). Further radiology exam showed the resident had consolidation (hardening of the normally soft lung tissue making it harder for the resident to breath) throughout the right lung and at the outer areas of the mid to upper left lung.

In an interview on 9/11/2025 at 3:06 PM, Collateral Contact 5 (CC5), Resident Representative, stated that Resident 1 had a significant decline in their health after they were infected with Legionella. The resident had declined significantly due to the permanent lung damage, making it harder for the resident to breath and Resident 1 required continuous oxygen that has required to be increased as the resident's lung status declined.

<Water contamination>

Review of a Washington State Department of Health (DOH) report, titled, "Office of Communicable Disease Epidemiology Legionella Response Team," dated 06/17/2025, showed that Resident 1 had symptoms of Legionella on 05/03/2025 and had positive Legionella urine antigen test on [redacted]/2025. After the facility notified the Local Health Jurisdiction (LHJ), the LHJ did a facility visit on 05/21/2025 and collected 57 swab and water samples within the facility. Out of the 57 samples collected, 26 (45.6%) of the samples detected Legionella. This report showed that the facility was to implement Immediate Control Measures. The immediate control measures included:
1) To avoid creating aerosols in resident facing water fixtures including showers and sinks.
2) POU filters were to be placed on any showerhead or faucets intended for resident use.
3) Avoid consumption of non-sterile ice from the facility ice machine for anyone with swallowing difficulties.
The report showed additional recommended control measures:
> An environmental assessment to be done by the LHJ and DOH.
> Hire water consultant company to perform water remediation and post-mediation test to be performed.
> Create a Water Management Plan (WMP) in consultation with the water consultant company.
> Notify current residents, family and staff of possible exposure, including notification of any new admissions to the facility.
> Notify DSHS of positive Legionella results.
> Monitor residents for symptoms of pneumonia or Legionnaires disease and have a low threshold for testing.
> Conduct review of residents for past year looking for residents who had unexplained pneumonia.
> Test residents who had in-house acquired pneumonia for past three months using urine antigen testing.
> Develop flushing plan for showers and sinks.
> Clean all facility ice machines according to manufacturer instructions, remove any carbon filters and replace water line if cloudy
> Perform routine cleaning and maintenance on hot water storage tanks. Monitor the bottom of water tanks used in resident areas to ensure they are at the recommended temperature of 140 degrees Fahrenheit so that the water at point of use is at 120 degrees Fahrenheit at point of use.
> Once Point of Use (POU) filters installed, make sure to drain all shower hoses properly after use before they are rehung in a "U" shape. The hoses were to hang vertically, without the showerhead hitting the ground.
> Ensure all windows and doors are closed in areas near outdoor sprinklers when sprinklers are in use. Adjust sprinklers to times when residents are less likely to be active near the sprinklers.
The report provided resources to the facility for the POU filters, an environment assessment from CDC, and CDC guidance on retrospective review and timeline for active clinical surveillance.

Record review of an electronic communication sent from Collateral Contact 1 (CC1), LHJ Deputy Administrator, to Staff B, Health and Wellness Director, dated 06/18/2025 at 2:57 PM, showed that the LHJ sent a copy of the 05/21/2025 Legionella test results

including a summary of the positive samples that were levels indicating poorly controlled growth of Legionella. Attached to the email were immediate control recommendations from the LHJ, a list of POU filters and the Legionella lab reports.

Record review of an electronic communication sent to Staff B on 06/18/2025 at 2:57 PM, showed that Staff B emailed Staff E, Senior Operations Director of Ancillary Services, Staff C, Operations Consultant and Staff D, Regional Operations Lead, to provide them with copies of the attachments and to inform them of the plan to speak with CC1 to discuss the next plans that the facility was going to take.

Record review of an electronic communication dated 06/25/2025 at 6:14 PM, showed CC1 had a phone meeting on 06/25/2025 with Staff A, Executive Director, and was informed that the water testing showed extremely high levels of Legionella in the community water system and had received directions of immediate actions to include:
> Install filters on all shower heads and sink faucets.
> Thoroughly clean and descale all shower heads and faucets.
> Flush all water lines to clear out stagnant water and potential bacteria buildup.
> Clean the boiler system and remove all sediment build-up.
> Restrict all resident and staff showers until further notice with sponge baths recommended.
> Do not use any ice machines, discard current ice and shut down machines.
> Increase hot water tank temperature to 140 degrees Fahrenheit.

In a response email, dated 06/25/2025 at 5:53 PM, Staff F, Regional Remodel Project Manager stated that it was probably more than they need but it was good information and that Staff A should probably still do the list of items immediately.

Record review of public health report, titled, "Food Establishment Inspection Report," undated, (per Staff A, report provided to them on 07/01/2025 onsite assessment) showed, corrective actions listed for new filters on ice machine, apartment lines flushed weekly, plumber bids for mixing valves bid by the following week for 9 boilers and repipe boilers for mixing valves, bottled water to be used, do not use ice until lines were drained and decontaminated and hire consulting company for WMP and decontamination. Observations showed there were no water filters for faucets and shower heads and notes the facility were still researching and would be obtaining those filters.

Record review of Department of Health (DOH) report, titled, "Office of Communicable Disease Epidemiology Legionella Response Team," dated 07/07/2025 showed the LHJ and DOH provided an onsite environmental assessment on 07/01/2025 for the positive Legionella in the facility water. The report showed that the facility was requested to implement immediate control measures intended to restrict use of potable water by residents until measures were taken to remediate the potable water system and reduce the risk of Legionella exposure. The document further showed the city water supply entering into the facility was disinfected by chlorine and there were no interruptions of the incoming water supply, no construction or utility work that would have impacted the

water supply during the exposure period.

DOH report continued to state the facility was requested to implement immediate measures intended to restrict use of potable water by residents until measures were taken to remediate the potable water system and reduce the risk of Legionella exposure to residents, staff and visitors of the facility. Review of hot water storage tanks assessed showed that the facility should ensure safe operation of all hot water storage tanks, they should all (including those in private apartments) receive monthly maintenance and periodic draining and cleaning. The hot water tanks have to have temperature gauges. The document further showed the LHJ and DOH staff completing the assessment followed on measures provided on 06/17/2025 report, including showers, water lines with stagnation,

Review of electronic communication from CC1 to Staff A, Collateral Contact 3 (CC3), LHJ Supervisor of Food and Living Environments Programs, and Collateral Contact 4 (CC4), DOH Epidemiologist, dated 07/09/2025 at 3:38 PM, showed that CC1 had inquired about all immediate restrictions that had been placed into action and requested an update regarding the remedial measures for the Legionella.

Review of an electronic communication from CC3 to CC1 dated 07/10/2025 at 5:28 PM, showed that CC3 followed up with Staff A for updates on what the facility had implemented per the control measures:
>the facility was still using the ice machine and tap water.
>the facility had not started a flushing system for water lines.
>the facility had not hired a water consultant and CC3 had to explain that the facility would need them to create a water management plan and decontaminate the water system. Staff A told CC3 that their maintenance director would put a WMP into place when they returned from paternity leave (Planned return was 08/18/2025).
>the facility had not obtained point of use water filters for shower and faucet heads and told CC3 that they were not sure the POU filters were required.
>Staff A indicated to CC3 that they did not feel it to be reasonable to direct residents to not use their patios during times when irrigation sprinklers were on.

Review of the Local Health Jurisdiction (LHJ) report titled, "Order of the Local Health Officer," dated 07/29/2025, findings in this report showed that the facility's residents were at heightened risk of severe illness. The report further showed that the LHJ provided guidance facility failed to implement the 7 "Immediate Control Measures," and 13 "Full Remediation and Long-Term Measures" in a timely or complete manner.

Review of electronic communication, dated 08/07/2025 at 11:03 AM, showed that Staff A had sent an email to CC3 to inform them that they had received the Order of the Local Health Officer and was providing an update on where the facility stood. A summary of actions were provided which included: weekly water flushing protocol implemented, ice machine maintenance including draining, cleaning, and installing new filters. Mixing valves were scheduled to be installed on 08/14/2025 on all eight of the facility's hot water systems, hot water tank maintenance task was added to the facility's

maintenance log, point of use filters were being researched but in the meantime the facility was inspecting shower and faucets for cleanliness and scaling as well as any shower heads that touched the ground would be replaced immediately, a letter was sent to all residents and their families explaining about the Legionella and what symptoms to watch for and a water management plan was written. Further review of this email showed that CC3, Staff C, Staff D, Staff E and Staff F were copied.

On 08/11/2025 at 1:55 PM, CC1 responded to the electronic communication with some follow-up questions:
•Aside from the water restrictions, what efforts had been taken to eliminate the pathogen within the water supply (treatment)?
•Has shower use been restricted? If so, when did the restriction go into effect?
•When will point-of-use filters be obtained/installed?
•What company/consultant was being used for remediation/water management plan?
This email was copied to CC3, Staff C, Staff D, Staff E, and Staff F.

Staff A responded to the electronic communication on 08/28/2025 at 1:10 PM, (response was 17 days after CC1 sent their follow up questions). This email showed the facility was working toward "putting all the pieces together to rid us of all Legionella." A comprehensive water management plan was developed (by Staff G, Maintenance Director of Senior Living Facilities), residents and DSHS were notified. Implemented a flushing program, cleaned ice machine and replaced filters and maintenance of hot water heaters. It was verified that the outside sprinklers were not spraying toward doors and windows. Furthermore, the email stated that the previous resident records were reviewed for pneumonia, to assure there were no missed cases and that the facility had begun the process of adding mixing valves to the hot water systems

As of 09/05/2025, visit by the department showed the review of record records review were not done to ensure there were no missed cases, and the mixing valves had not been installed nor ordered.

Review of an email from CC2 to the Washington State Department of Health, dated 08/29/2025 at 4:14PM, showed that LHJ was reaching out for guidance regarding the Legionella contamination in the facility's water and their lack of timely response to the LHJ's remedial requirements including a 30-day mandate requiring corrective action that was issued on 07/29/2025. The email further showed that Legionella had been present in the water for more than 100 days and there were concerns because of the facility's inaction putting the resident at ongoing risk of exposure to Legionella.

Interview on 09/05/2025 at 12:25 PM, Staff A stated that they had not put any control measures in place to decrease resident exposure to the contaminated water. Staff A stated that they had not purchased the water filters because of the $70,000 cost every 62 days and the mixing valves were put on hold because they were working with a plumber on a plan for a water filtration system but had not yet had this plan approved by the LHJ. Staff A further stated that they had not searched for or hired a water management company for remediation.

In an interview on 09/05/2025 at 12:45 PM, Staff B stated that they had not been included in the communications related to the reports from the LHJ and had not been provided with instructions to complete any review of resident records for residents who had pneumonia and had not been told to place residents on monitoring for symptoms of Legionella and that they were supposed to test at a low threshold.

Observations on 09/05/2025 at 1:50 PM showed that resident showers and sink had water in the shower hoses and sinks were accessible to residents without filters in place and no signage posted regarding Legionella in the facility water and there were not bottles of drinking water in resident rooms for residents to drink from.

In an interview on 09/17/2025 at 12:45PM, Staff A stated when they received verbal guidance and written reports from the LHJ, they sent the information to the regional team (Staff C, Staff D, Staff E and Staff F, Remodel Project Manager). Staff A stated that when they communicated with the regional team, they did implement some of the items as per the guidance they received from Staff F that would have decreased resident's exposure to the Legionella, such as stopping use of showers and sinks as an immediate intervention and installing the POU filters that were recommended to filter out the Legionella in resident areas as a measurement to protect residents until the water remediation could be completed. Staff A stated they did not have a good answer regarding why the immediate measures were not implemented and they followed the instructions given to them by Staff F and regional team. Staff A further stated that since there was only one resident that got sick, they felt like there was not much urgency because of the word "recommendation" in the reports.

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, Colonial Vista Senior Living is or will be in compliance with this law and / or regulation on (Date) 12/19/2025

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

Brooke Capps 12/2/2025

Administrator (or Representative) Date

WAC 388-78A-2650 Reporting fires and incidents. The assisted living facility must immediately report to the department's aging and disability services administration:

(2) Any unusual incident that required implementation of the assisted living facility's disaster plan, including any evacuation of all or part of the residents to another area of the assisted living facility or to another address; and

(3) Circumstances which threaten the assisted living facility's ability to ensure continuation of services to residents.

This requirement was not met as evidenced by:

Based on interview and record review, the assisted living facility failed to report to the Department's Complaint Resolution Unit (CRU) when the Local Health Jurisdiction reported the facilities water had tested positive for a Legionella and required interruption of the facility water service for residents. This failure resulted in a delayed investigation by the department.

Findings included...

Review of a report from the Local Health Jurisdiction (LHJ), titled, "Order of the Local Health Office," dated 07/29/2025, showed that facility water samples were collected on 05/21/2025, and confirmed the presence of Legionella bacteria at levels consistent with an increased risk of disease transmission. The order further showed the residents were at heightened risk of severe illness from exposure to the contaminated water. The immediate measures to decrease the risk of resident exposure to the contaminated water was to avoid the use of water facility water including sink and tub faucets in resident rooms, restrict resident showers and provide residents with bottled water for drinking.

In an interview on 09/05/2025 at 12:12 PM, Staff A, Executive Director, stated they did not report to the department when they had a positive Legionella test of the facility's water. Staff A acknowledged that the facility had received communication from the Local Health Jurisdiction regarding the high risk of illness to the facility's residents from exposure to the contaminated water. They further acknowledged that the residents should not have been using the facility water for showering, hand washing or drinking.

In an interview on 09/17/2025 at 12:45 PM, Staff A stated that the residents' water services had to be interrupted due to the legionella, and they had placed residents, staff and visitors at risk of exposure and acknowledged that the positive legionella in the facility water should have been reported to the department.

Statement of Deficiencies	License #: 2712	Compliance Determination # 65207
Plan of Correction	Colonial Vista Senior Living	Completion Date
Page 10 of 10	Licensee: Colonial Vista Community Healthcare, LLC	11/13/2025

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, Colonial Vista Senior Living is or will be in compliance with this law and / or regulation on (Date) 12-19-2025.

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

Brooke Capps — Administrator (or Representative)

12/2/2025 — Date

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

Colonial Vista Community Healthcare, LLC
Colonial Vista Senior Living
601 OKANOGAN AVE
WENATCHEE, WA 98801

RE: Colonial Vista Senior Living # 2712

Dear Administrator:

The Department completed a complaint investigation of your Assisted Living Facility on 11/13/2025 and found that your facility does not meet the Assisted Living Facility requirements.

The Department:

- Wrote the enclosed report; and
- May take licensing enforcement action based on any deficiency listed on the enclosed report; and
- May inspect the facility to determine if you have corrected all deficiencies; and
- Expects all deficiencies to be corrected within the timeframe accepted by the department.

You Must:

- Begin the process of correcting the deficiency or deficiencies immediately;
- Contact the Field Manager for clarifications related to the Statement of Deficiencies (SOD);

- Within 10 calendar days after you receive this letter, complete and return the enclosed 'Plan/Attestation Statement';
  - o Sign and date the enclosed report;
  - o For each deficiency, indicate the date you have or will correct each deficiency;
  - o Next to each deficiency, sign and date certifying that you have or will correct each cited deficiency; and
  - o Return the Plan/Attestation Statement and report with signatures to:

Laura Williams-Davis, ALF Field Manager
Residential Care Services

Region 1, Unit G
Preferred methods:
eFax: (509) 454-4160
Email: rcsregion1email@dshs.wa.gov
Optional method:
1200 Alder Street
Union Gap, WA 98903

• Complete correction(s) within 45 days, or sooner if directed by the Department, after review of your proposed correction dates.
• Have your plan approved by the Department.

Consultation(s):
In addition, the Department provided consultation on the following deficiency or deficiencies not listed on the enclosed report.

WAC 388-78A-2040 Other requirements.

(1) The assisted living facility must comply with all other applicable federal, state, county and municipal statutes, rules, codes and ordinances, including without limitations those that prohibit discrimination.

The facility was issued a stop placement due to failure to comply with immediate control measures directed by the Local Health Jurisdiction. Once implemented the stop placement was lifted and the citation was modified.

You Are Not:
• Required to submit a plan of correction for the consultation deficiency or deficiencies stated in this letter and not listed on the enclosed report.

You May:
• Contact me for clarification of the deficiency or deficiencies found.

In Addition, You May:
• Request an **Informal Dispute Resolution (IDR)** review within 10 working days after you receive this letter. Your IDR request **must** include:
  o What specific deficiency or deficiencies you disagree with;
  o Why you disagree with each deficiency; and
  o Whether you want an IDR to occur in-person, by telephone or as a paper review.
  o You can make an IDR request and find directions on the IDR web page at:
    https://www.dshs.wa.gov/altsa/idr

If You Have Any Questions:
• Please contact me at (509)208-5231.

Sincerely,

Laura Williams-Davis, ALF Field Manager
Region 1, Unit G
Residential Care Services

Enclosure