STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING 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) 74566 (Completion Date 03/19/2026) and 71086 (Completion Date 02/19/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 03/19/2026 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-2450-1-a, WAC 388-78A-2450-2-e, WAC 388-78A-2450-2-h-iii, WAC 388-78A-2210-1-b, WAC 388-78A-2210-2-a

The Department staff who did the on-site verification:
Brittney Shull, 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: 205398
Compliance Determination #: 71086
Region/Unit #: RCS Region 1 / Unit G
Investigator: Brittney Shull
Investigation Date(s): 01/07/2026 through 02/19/2026
Complainant Contact Date(s): 02/18/2026

Allegation(s):
The named resident did not receive pain medication when requested.

Investigation Methods:

Sample:	Total residents: 24 Resident sample size: 3 Closed records sample size: 1
Observations:	Environment, Residents, Staff to resident interactions, Medication pass.
Interviews:	Residents, Staff, Collateral Contacts.
Record Reviews:	Characteristic Roster, Resident records, Resident Assessment, Negotiated Service Agreement, Progress Notes, Incident Report and Investigation, Staff Schedule, Facility Policy.

Investigation Summary:
Interview and record review showed that the facility was not staffed to meet resident medication needs. Interview and record review showed that a medication error occurred. Failed practice identified. Reference Statement of Deficiency for WAC 388-78A(2450) and WAC 388-78A(2210).

Conclusion / Action:

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

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1200 Alder Street, Union Gap, WA 98903

Statement of Deficiencies	License #: 2712	Compliance Determination # 71086
Plan of Correction	Colonial Vista Senior Living	Completion Date
Page 1 of 7	Licensee: Colonial Vista Community Healthcare, LLC	02/19/2026

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 01/07/2026 and 01/15/2026 of:

Colonial Vista Senior Living
601 OKANOGAN AVE
WENATCHEE, WA 98801

This document references the following complaint number(s): 205398, 206891

The following sample was selected for review during the unannouncec on-site visit: 3 of 24 current residents and 1 former residents.

The department staff that investigated the Assisted Living Facility:

Brittney Shull, Community Complaint Investigator

From:
DSHS, Home and Community Living 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
Residential Care Services

02/24/2026
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
Administrator (or Representative)

2/24/2026
Date

WAC 388-78A-2450 Staff.

(1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with their negotiated service agreement;

(2) The assisted living facility must:

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience, and other qualifications necessary to provide the care and services;

(h) Provide staff orientation and appropriate training for expected duties when staff begin work in the facility, including, but not limited to:

(iii) Specific duties and responsibilities;

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to ensure sufficient staff were trained and available to meet the medication assistance needs for 1 of 4 residents (Resident 1). This failure resulted in delayed pain relief for Resident 1 and placed residents at risk for unmet medication needs and medication errors.

Findings included...

Review of the facility's policy titled, "PRN [as needed] Medications," dated 2023, showed that only properly trained staff of the community could provide PRN medication administration. The policy showed that staff must be trained, with documentation on file. The policy showed that PRN medications must be administered according to the prescriber's orders. The policy showed that staff administering medications would verify

the seven rights of medication administration: right person, right medication, right time, right route, right dose, right reason, right documentation. The policy also showed that staff were required to document whether the PRN medication was effective.

Review of the facility's December 2025 staff schedule showed that there had been no medication technician, available to provide medication assistance, scheduled for night shift (10:00pm to 6:00am) on 12/08/2025, 12/13/2025, 12/14/2025, 12/19/2025, 12/20/2025, 12/25/2025, 12/26/2025, 12/27/2025, and 12/31/2025.

Review of the facility's January 2025 staff schedule on 01/15/2026 showed that there had been no medication technician available to provide medication assistance, scheduled for night shift on 01/01/2026, 01/02/2026, 01/06/2026, 01/07/2026, 01/12/2026, 01/13/2026. The schedule showed that there was no scheduled medication technician for 01/18/2026, 01/19/2026, 01/24/2026 or 01/25/2026.

Resident 1

Review of Resident 1's Assessment, dated 12/10/2025, showed that Resident 1 had a diagnosis of [redacted] and staff were directed to observe for signs or statements of increased pain, document the pain, and notify Staff B, Health and Wellness Director. The assessment showed that Resident 1 required assistance with medications.

Review of Resident 1's Negotiated Service Agreement (NSA), dated 12/11/2025, showed that staff were required to provide medication assistance to Resident 1. The NSA showed that Resident 1 was at risk of pain due to arthritis and staff were to administer medications for pain relief and assess effectiveness.

Review of Resident 1's Physician Orders, dated 12/11/2025, showed that Resident 1 had an order for Tylenol to be given every four hours as needed for pain.

Review of Resident 1's Progress Note, dated 12/14/2025 at 1:44pm, showed that Resident 1 had a "rough morning and had hip and body pain," and as needed Tylenol was effective for the pain.

Review of Resident 1's Progress Note, dated 12/14/2025 at 9:20pm, showed that Resident 1 had requested Tylenol at bedtime to "make it through the night."

Review of Resident 1's December 2025 Medication Administration Record (MAR) showed that Resident 1 had not received any Tylenol on 12/13/2025. The MAR showed that Resident 1 received Tylenol on 12/14/2025 at 6:29am for a pain level of 5 out of 10.

In an interview on 01/07/2026 at 1:52pm, Staff C, Caregiver, stated that Resident 1 requested pain medication on the evening of 12/13/2025. Staff C stated they did not pass medications and medication technicians had the duty of administering medications. Staff C stated they were not supposed to pass medications until they received training from Staff B. Staff C stated they had attempted to contact off-duty medication technicians to assist with administering the Tylenol and could not reach anyone because it was late at night.

Review of the prepared medication education for Staff C on 01/07/2026 (that had not yet been provided, 25 days after the incident on 12/13/25, and after 10 night shifts without a medication tech on duty), showed that Staff C, Caregiver, was to be trained on the rights of medication administration.

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) 2/25/2026

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

Brooke Capps — Administrator (or Representative)

2/25/2026 — Date

WAC 388-78A-2210 Medication services.

(1) An assisted living facility providing medication service, either directly or indirectly, must:

(b) Develop and implement systems that support and promote safe medication service for each resident.

(2) The assisted living facility must ensure the following residents receive their medications as prescribed, except as provided for in WAC 388-78A-2230 and 388-78A-2250 :

(a) Each resident who requires medication assistance and his or her negotiated service agreement indicates the assisted living facility will provide medication assistance; and

This requirement was not met as evidenced by:

Based on interview and record review, the Assisted Living Facility (ALF) failed to implement a safe medication delivery system and to ensure medications were administered as prescribed for 1 of 4 residents (Resident 2). This failure resulted in Resident 2 receiving a dose of medication that was above the prescribed amount and

placed the resident at risk for health complications.

Findings included...

Review of the facility's policy titled, "PRN [as needed] Medications", dated 2023, showed that only properly trained staff of the community could provide PRN medication administration. The policy showed that staff must be trained, with documentation on file. The policy showed that PRN medications must be administered according to the prescriber's orders. The policy further showed that staff administering medications would verify the seven rights of medication administration: right person, right medication, right time, right route, right dose, right reason, right documentation.

Review of Resident 2's Nurse Delegation documentation, dated 12/17/2025, showed that Resident 2 required administration of all oral medications. The delegation form directed staff to measure the exact amount of liquid medication needed using a dropper or syringe and to assist Resident 2 with opening their mouth if needed and placing medications in their mouth. Review of the form showed that Staff H, Medication Technician, was not included on the delegation form.

Review of Resident 2's Negotiated Service Agreement (NSA), dated 01/15/2025, showed that staff were required to provide medication assistance to Resident 2. The NSA showed that Resident 2 was at risk of pain due to arthritis (joint inflammation), multiple sclerosis (disease that causes nervous system damage) and contractures (restricted mobility of limbs caused by shortening and hardening of muscles and tendons), and that staff were to administer medications for pain relief and assess effectiveness. The NSA showed that Resident 2 could not always communicate a need for PRN medications.

Review of Resident 2's Assessment, dated 03/31/2025, showed that Resident 2 had a diagnosis of [redacted] and [redacted] The assessment directed staff to observe for signs or statements of increased pain, document the pain, and notify the Health and Wellness Director. The assessment showed that Resident 2 required assistance with medications.

Review of Resident 2's January 2026 Medication Administration Record (MAR) showed that Resident 2 had an order for 0.8 milliliters (ml) or 8 milligrams (mg) Methadone (pain medication) twice daily for pain. The MAR showed that a dose of methadone had been given on 01/10/2026 at 8:00 pm.

Review of the facility's Investigative Summary, dated 01/12/2026, showed that Resident 2 had run out of methadone due to Staff H administering too much methadone to the resident by using a medication cup to measure the liquid instead of a syringe.

Review of Resident 2's Progress Note, dated 01/15/2026, showed that on 01/10/2025 at 8:00 pm, the resident was given significantly more methadone than prescribed. The note showed that Resident 2 was noted to be drowsy.

In an interview on 01/15/2026 at 12:18pm Staff B, Health and Wellness Director, stated that Resident 2's methadone had run out early. Staff B stated that they had learned that Staff H had provided Resident with a dose of liquid methadone that was above the dose prescribed due to measuring the wrong dose. Staff B stated that Staff H showed them that they had used a medication cup and had given 8 ml of methadone instead of properly using a syringe to measure 0.8ml (resulting in an overdose of 72mg). Staff B stated Resident 2 had been sleepy before they had discovered the error. Staff B further stated that their regional director had identified a training checklist (Competency Checklist) that the medication technicians should complete prior administering medications. Staff B stated that they did not have any records of medication administration training for Staff H or any other medication technicians.

Record review of a blank Competency Checklist on 01/15/2026, showed that staff were to demonstrate proper steps of medication administration including, rights of medication administration and counting narcotics. The checklist showed that the evaluator was to determine if medication technician staff had necessary skills to safely pass medications or needed further training before passing medications unsupervised.

In an interview on 02/04/2026 at 2:59pm, Collateral Contact 1 (CC1), Resident Representative, stated that Resident 2 had neck pain from their multiple sclerosis. CC1 stated they believed Resident 2's pain was usually well controlled with repositioning and scheduled methadone. CC1 stated they were notified that Resident 2 had received the wrong dose (too much) methadone. CC1 stated that around the same time the medication error had occurred, Resident 2 had a three-day period of not eating and was very unresponsive. CC1 stated that they had initially thought Resident 2's body was "shutting down" due to their health condition. CC1 stated that they were told the error was caused by a new staff member and that the new staff member needed training.

Statement of Deficiencies	License #: 2712	Compliance Determination # 71088
Plan of Correction	Colonial Vista Senior Living	Completion Date
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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) 2/25/2026.

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

Brook L. Capps — Administrator (or Representative)

2/25/2026 — Date