STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505413	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide adequate supervision during meals consistent with resident needs for 1 of 3 residents (Resident 15) reviewed for accidents and supervision. This failure placed Resident 15 at risk for choking and adverse health outcomes. Findings included. Resident 15 Review of the resident's medical record showed they were admitted to the facility with diagnoses which included cerebral palsy (a disease due to abnormal brain development which causes disorders of movement, muscle tone and posture), and dysphagia (difficulty swallowing). Review of the comprehensive assessment dated [DATE] showed the Resident 15 was cognitively intact and dependent on staff for dressing, grooming and personal hygiene however they were able to eat independently after their meal was set up. Review of a physician order dated 08/20/2025 showed Resident 15's diet was regular texture with soft bite sized pieces served with gravy or sauce to decrease choking risk and thin liquids with straws to maintain swallowing precautions. Resident 15's care plan updated on 08/12/2025 showed the resident had identified choking risks related to their diagnosis of dysphagia. The intervention outlined in their care plan was to provide monitoring and supervision during meals for choking, coughing and/or holding food in their mouth without swallowing. During an observation on 08/18/2025 at 12:36 PM, showed Resident 15 was sitting at a table in the activity room with another resident eating their meals. The residents were eating alone with no staff providing any monitoring or supervision during the meal. During an interview on 08/18/2025 at 12:50 PM, Resident 15 stated they ate most of their meals with the unidentified resident in the activity room as they enjoyed each other's company and were good friends. Resident 15 stated they needed the other resident when they ate because they were afraid of choking on their food and further stated the nursing staff did not monitor them or provide them with supervision during their meals. During additional observations of Resident 15's meals showed on 08/19/2025 from 12:18 PM to 12:51 PM no staff supervision, on 08/20/2025 from 8:10 AM to 9:00 AM no staff supervision and on 08/20/2025 from 12:17 PM to 12:55 PM there was no staff in the activity room providing supervision or monitoring Resident 15 for choking during their meals. During an interview on 08/20/2025 at 12:14 PM, Staff L, Nursing Assistant, (NA), stated the nursing staff did not provide supervision for Resident 15 during meals as they were not aware they had swallowing precautions. During an interview on 08/21/2025 at 10:20 AM, Staff K, Regional Nurse, stated nursing staff should be providing supervision for Resident 15 during meals as they had dysphagia and were at risk for choking when they ate. Reference WAC388-97-1060(3)(g)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505413	A. Building B. Wing	08/22/2025

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Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Infection Prevention and Control Guidelines and standards of practices were followed; 1. During a facility COVID-19 (an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death) outbreak to mitigate the risk for transmission of COVID-19 on 1 of 3 halls (South Hall); 2. During a residents Peripherally Inserted Central Catheter [(PICC) a long thin tube inserted through a vein in an arm to the heart to administer fluids, medications, and blood draws] dressing change for 1 of 2 residents (Resident 79). These failures placed residents, staff and visitors at risk for exposure to cross contamination (harmful spread of diseases) and the transmission of infectious diseases. Findings included. Review of the 06/2025 Washington State Department of Health SARS-CoV2 Infection Prevention and Control in Healthcare Settings Toolkit, showed long term care facilities were to conduct unit-wide testing and continue testing all residents and staff on the affected unit who previously tested negative every three to seven days for a minimum of 14 days from the most recent positive result, or the Licensed Health Jurisdiction direction. COVID-19 Testing During an interview on 08/19/2025 at 10:47 AM, Staff C, Infection Preventionist, stated the facility had admitted a resident with COVID-19 in July 2025 to the South Hall and was placed in quarantine and placed on aerosol contact precautions. Staff C stated a resident tested positive on 07/22/2025 when they went to the hospital for an emergency visit unrelated to COVID-19. Staff C stated three additional residents tested positive on 07/23/2025, when they experienced a low-grade fever, weakness, and a sore throat. Staff C stated they notified the Department of Health (DOH) and informed them they had closed the South Hall unit to include the dining room, activities and to other residents and staff. Staff C stated on 07/25/2025 another resident tested positive for COVID-19 and a staff member after they had symptoms of a moist cough, scratchy throat and lethargy (lack of energy) and on 07/26/2025 a second staff member tested positive after working the night shift in South Hall. Staff C stated the facility did not perform COVID-19 testing for all residents and staff during the outbreak. Staff C stated the facility performed testing for symptomatic residents only. Staff C stated in total there were six residents and three staff members who were COVID-19 positive during the outbreak and the outbreak ended on 08/11/2025. During a follow-up interview on 08/20/2025 at 1:50 PM, Staff C stated they did receive the WA DOH Toolkit and did not review in its entirety, therefore did not complete the required COVID-19 testing. During an interview on 08/20/2025 at 11:43 AM, Collateral Contact, Communicable Disease Specialist from the Local Health Jurisdiction (CC), stated they had been in communication with the facility for the COVID-19 outbreak. The CC stated they provided guidance to the facility and the IP and emailed the [NAME] Department of Health Covid toolkit. The CC stated they had requested updates from the facility on the COVID-19 outbreak. The CC stated the information they were provided with showed a line listing of residents and staff when they tested positive. The information also showed on 07/24/2025, 07/28/2025, 07/29/2025, 07/30/2025, and 07/31/2025 the facility had no new COVID-19 positive residents or staff. The CC stated when they received the information showing no new positives, they believed they facility had been continuing COVID-19 testing per the guidance, and they were unaware the facility had not continued to test the residents and staff. The CC stated the facility should have conducted COVID-19 testing of all residents and staff in the affected unit to ensure there were no Covid-19 residents and staff identified. The CC stated the WA DOH Toolkit they provided did show the facility was required to continue testing of all residents and staff who previously tested negative every three to seven days for a minimum of 14 days from the most recent positive result. During an interview on 08/20/2025 at 2:02 PM, Staff K, Regional Nurse, stated they were not aware there were additional residents who tested COVID-19 positive and if they had been made aware the facility should have continued COVID-19 testing per the guidelines. PICC Review of the medical record showed Resident 79 was admitted with diagnoses including endocarditis (a serious infection of the heart lining), and a PICC line for antibiotic therapy. The 07/24/2025 comprehensive assessment showed Resident 79 required substantial/set-up assistance of one to two staff for activities for daily living and had an intact cognition. During an observation and concurrent interview on 08/21/2025 at 4:27 PM, Staff H, Registered Nurse, prepared to perform a PICC dressing change on Resident 79. Staff H performed hand hygiene, donned (put on) gloves and used a disinfecting wipe and