STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HOME AND COMMUNITY LIVING ADMINISTRATION
***800 NE 136th Ave Ste 200, Vancouver, WA 98684***

04/28/2026

White Oak Village LLC
White Oak Village Memory Care Community
14715 NE 20th Ave
Vancouver, WA 98686

RE: White Oak Village Memory Care Community # 2738

Dear Administrator:

This letter addresses deficiencies occurring in the report(s) for: Compliance Determination(s) 75694 (Completion Date 04/28/2026) and 69867 (Completion Date 02/10/2026).

The Department completed a follow-up inspection of your Assisted Living Facility on 04/28/2026 and found no deficiencies.

The Department found that deficiencies for the following licensing laws and regulations were corrected:
**WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:**

(4) Take appropriate action in response to each resident's changing needs.

The Department staff who did the On Site verification:
Yvonne Chitekwe

If you have any questions, please contact me at (360)450-1218.

Sincerely,

Clinton Fridley, RN

Clinton Fridley, Community Nurse Field Manager
Region 3, Unit E
Residential Care Services

# Residential Care Services
## Investigation Summary Report

**Provider/Facility:** White Oak Village Memory Care Community
**Provider Type:** Assisted Living Facility
**License/Cert.#:** 2738
**Intake ID:** 204922
**Compliance Determination #:** 69867
**Region/Unit #:** RCS Region 3 / Unit E
**Investigator:** Yvonne Chitekwe
**Investigation Date(s):** 12/09/2025 through 02/10/2026
**Complainant Contact Date(s):**

**Allegation(s):**

1. Death- General: Allegation of resident's injuries that were caused by another resident resulted to their death.

2. Quality of Care/Treatment: Allegation of facility response to a resident's physical and verbal aggressive behaviors that resulted to a resident's fall causing fatal injuries.

**Investigation Methods:**

| | |
|---|---|
| **Sample:** | Total residents: 49<br>Resident sample size: 3<br>Closed records sample size: 2 |
| **Observations:** | Residents<br>Activities<br>Identified resident<br>Dining<br>Resident care equipment<br>Resident rooms<br>Staff to resident interactions<br>Resident to resident interactions |
| **Interviews:** | Identified staff<br>Nursing staff<br>Residents<br>Family members |
| **Record Reviews:** | Incident investigation<br>Resident Characteristic Roster<br>Staff List<br>progress notes<br>negotiated careplan |

**Investigation Summary:**

1. Death- General: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations

and records review, no failed facility practice in the allegation of resident's injuries that were caused by another resident resulted to their death was substantiated during the investigation.

2. Quality of Care/Treatment: The on-site investigation was conducted in relation to all allegations and incidents identified in the intake. Based on interviews, observations and records review, failed facility practice in the allegation of facility's response to a resident's physical and verbal aggressive behaviors that resulted to a resident's fall causing fatal injuries was substantiated during the investigation.

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**Conclusion / Action:**

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

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| Statement of Deficiencies | License #: 2738 | Compliance Determination #69867 |
|---|---|---|
| Plan of Correction | White Oak Village Memory Care Community | Completion Date |
| Page 1 of 5 | Licensee: White Oak Village LLC | 02/10/2026 |

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 12/09/2025 of:

White Oak Village Memory Care Community
14715 NE 20th Ave
Vancouver, WA 98686

This document references the following complaint number(s): 203693, 204922

The following sample was selected for review during the unannounced on-site visit: 3 of 49 current residents and 2 former residents.

The department staff that investigated the Assisted Living Facility:

Yvonne Chitekwe

From:
DSHS, Home and Community Living Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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.

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.

Austin Hill (Austin Hill) — 3/11/26
Administrator (or Representative) — Date

**WAC 388-78A-2120 Monitoring residents' well-being. The assisted living facility must:**

(4) Take appropriate action in response to each resident's changing needs.

**This requirement was not met as evidenced by:**

Based on observation, interview and record review, the facility failed to take appropriate actions to protect the safety and well-being of 2 of 4 sampled residents (Resident 1(R1) and Resident 2(R2)) reviewed for a resident-to-resident incident. This failure resulted in R2 suffering a fall with injury and placed both residents at risk of harm and a decreased quality of live.

Findings included...

Resident 1

Record review of R1's undated admission record (face sheet) showed R1 moved into the facility on [redacted]/2025.

Record review of R1's Negotiated Service Agreement (NSA), dated 10/09/2025, showed R1 had a behavior of yelling, hitting doors and pacing. Other documented behaviors included anger, anxiety, verbal abuse, unable to avoid or discern situations of abuse or exploitation. R1's behavior management level of care was moderate with interventions of redirection, monitoring, cueing or reminders to prevent incidents,

Record review of R1's progress note, dated 10/09/2025 showed that R1 was having

unmanageable verbal and physical aggressive behaviors, putting hands on others, pushing, raising their voice at a female resident. At 10:35 AM, R1 was sent to the emergency room after interventions of monitoring and administering of R1's as needed medications did not work.

Record review of R1's progress note, dated 10/28/2025, showed R1, unprovoked, pushed and shoved another resident who was talking with facility staff. The other resident was heard shouting that R1 had just hit them on the forehead. R1 was monitored for increased agitation.

Record review of R1's progress note, dated 10/29/2025, showed that R1 became physically aggressive and agitated with a female resident by firmly gripping the other resident's wrist. The residents were separated and monitored.

Record review of R1's progress note, dated 11/29/2025, showed that R1 had ongoing aggressive behaviors that were unmanageable and threatened the safety of other residents despite staff applying interventions through verbal de-escalation, redirection and environmental modifications. Behaviors continued to escalate throughout the day.

Record review of R1's progress note, dated 11/29/2025, showed that R1's behavior worsened and was involved in three unprovoked physical altercations with other residents, and seriously injuring R2. The level of agitation had escalated significantly resulted in facility staff having to call emergency medical services and law enforcement to remove R1 from the community. R1 was taken to the hospital for evaluation.

Resident 2

Record review of R2's undated admission record (face sheet) showed R2 moved into the facility on [redacted]/2025 with diagnosis of [redacted] and [redacted].

Record review of R2's NSA, dated 09/18/2025, showed R2 was wheelchair-bound and required one person physical assistance for all transfers. R2 was weak, mobility status level of care: extensive (Daily assistance with ambulatory), had decreased gait mobility and poor gait and balance due to fracture, decreased range of motion.

Record review of R2's progress note, dated 11/29/2025, showed R2 was pushed and forcefully shoved by R1, causing R2 to fall to the floor and land on their right side. R2 cried in pain while on the floor. Three staff members picked R2 off the floor and placed into a wheelchair.

Record review of R2's progress notes dated 12/01/2025, showed R2 remained in bed all day with no interest in getting up. It also showed that R2 had a significant change in condition due to suspected right arm fracture from a physical altercation that happened on 11/29/2025 with R1.

Record review of R2's progress note, dated 12/01/2025, showed a Hospice nurse visited and discontinued all medications that were not specifically for comfort. It is documented that the hospice nurse stated that due to the fall, when the resident passes, the facility should notify the medical examiner prior to releasing the body to the funeral home.

Record review of R2's progress note, dated 12/02/2025, showed resident has remained in bed and cries out in pain when she is moved.

Record review of R2's progress note, dated 12/02/2025, showed resident has been experiencing severe pain since the resident to resident incident and that paid is being managed by hospice but due to the pain, the resident has remained in bed.

Record review of R2's progress note, dated 12/03/2025, showed resident staying in bed.

Record review of R2's progress note, dated 12/03/2025, showed resident is not doing well, is having mucus coming up in the mouth and having 'gurgling' sound when breathing.

Record review of R2's progress notes, dated 12/04/2025, showed resident was unable to take oral medications, hospice nurse visited and placed a rectal medication administration device because of the presence of excessive oral secretions. R2 in the afternoon was observed by staff to be comfortable in bed but not responding to verbal or physical stimuli.

Record review of R2's progress notes, dated [redacted]/2025, showed R2 passed away at 5:30 AM, hospice and family notified.

In an interview on 12/10/2025 at 1:38 PM, Collateral Contact 1 (CC1), Power of Attorney (POA) for R2, stated that the facility notified them that R2 was shoved by R1 and suffered a fall and hit the ground hard. CC1 showed up to the facility and found R2 crying and exhibiting a lot of pain. CC1 stated R1 was a "bully" and posed a danger to other residents and staff who expressed being very fearful of R1.

In an interview on 12/12/2025 at 9:40 AM, Staff A, Care Partner, stated that R1 was having behavior problems, yelled and threatened residents, pushing through people in the community on 11/29/2025. R1 "forcefully" pushed R2 which caused R2 to fall to the

ground resulting in injuries. R2 was bedridden from the injuries. Staff A stated that R1 had a very foul mouth and that R1 frightened many residents and staff. R1 was angry all the time.

In an Interview on 01/16/2026 at 10:28 AM, Collateral Contact 2 (CC2), Power of Attorney for Resident 4, stated that R1 got in verbal and physical altercations with residents and staff. R1 used foul language and would get in the faces of other people. CC2 stated that they felt that R1 posed a threat of physical harm to other residents. Residents, facility staff and visitors were fearful of R1's unpredictable, unprovoked verbal and physical altercations.

**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, White Oak Village Memory Care Community is or will be in compliance with this law and / or regulation on (Date) 3/11/26.

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

Administrator (or Representative) — Date: 3/11/26