STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
800 NE 136th Ave Ste 200, Vancouver, WA 98684

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

RE: White Oak Village Memory Care Community License # 2738

Dear Administrator:

This letter addresses Compliance Determination(s) 71452 (Completion Date 01/14/2026) and 66654 (Completion Date 11/20/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 01/14/2026 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-2630-1-a, WAC 388-78A-2630-1-b

The Department staff who did the on-site verification:
Jacob Ubl, ALF NCI CI

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

Sincerely,

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

This document was prepared by Residential Care Services for the Locator website.

Residential Care Services
Investigation Summary Report

Provider/Facility: White Oak Village Memory Care Community
License/Cert.#: 2738
Compliance Determination #: 66654
Investigator: Jacob Ubl
Investigation Date(s): 10/02/2025 through 11/20/2025
Complainant Contact Date(s):

Provider Type: Assisted Living Facility

Intake ID: 195891
Region/Unit #: RCS Region 3 / Unit E

Allegation(s):

1. Quality of Care/Treatment: Allegation that the Facility failed to appropriately address known allegations that a staff abused a Resident Alleged Victim.

Investigation Methods:

Sample:	Total residents: 33 Resident sample size: 6 Closed records sample size: 0
Observations:	Identified resident Residents Resident rooms Staff to resident interactions Resident to resident interactions
Interviews:	Identified resident staff Residents Family members
Record Reviews:	Medical records Incident investigation Facility policies

Investigation Summary:

1. Quality of Care/Treatment: Failed Practice Identified. The Facility failed to report the alleged abuse to CRU and law enforcement.

Conclusion / Action:

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

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DEPARTMENT OF SOCIAL AND HEALTH SERVICES

AGING AND LONG-TERM SUPPORT ADMINISTRATION

800 NE 136th Ave Ste 200, Vancouver, WA 98684

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 10/02/2025 and 11/20/2025 of:

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

This document references the following complaint number(s): 196436, 195891, 195600, 193662

The following sample was selected for review during the unannounced on-site visit: 6 of 33 current residents and 0 former residents.

The department staff that investigated the Assisted Living Facility:

Jacob Ubl, ALF NCI CI

From:
DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3 , Unit E
800 NE 136th Ave Ste 200
Vancouver, WA 98684

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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.

Administrator (or Representative) _____ Date _____

WAC 388-78A-2630 Reporting abuse and neglect.

(1) The assisted living facility must ensure that each staff person:

(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

(b) Makes an immediate report to the appropriate law enforcement agency and the department consistent with chapter 74.34 RCW of all incidents of suspected sexual abuse or physical abuse of a resident.

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to report alleged abuse to the Complaint Resolution Unit (CRU) for 1 of 6 sampled residents (Resident 1). This failure to notify CRU placed all 33 of 33 Residents at risk of unreported alleged abuse and prevented the department from evaluating facility systems in place to protect residents.

Findings included…

Record review of an undated Face sheet, showed Resident 1 (R1) was admitted to the AFH on [redacted]/2025 with a diagnosis of [redacted].

Record review of an incident report, dated 09/15/2025, showed R1 was allegedly verbally and physically abused by Staff C, a caregiver at the facility.

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Record review of facility policy titled, “Abuse, Neglect, and Exploitation Policy”, dated 03/27/2024, showed that the facility was to report suspected abuse to CRU and law enforcement.

The Facility was unable to provide documentation to show that CRU or law enforcement was notified of R1 allegedly being physically and verbally abused by Staff C on 09/15/2025.

In an interview on 09/25/2025 at 11:15 AM, Collateral Contact 1 (CC1) reported that the facility did not notify CRU of R1 allegedly being verbally abused by Staff C on 09/15/2025 at the facility. CC1 reported that they felt the facility management was purposely not reporting it so they didn’t have to terminate Staff C’s employment.

In an interview on 10/02/2025 at 11:34 AM, Staff A, executive director, reported that when Staff C allegedly physically and verbally abused R1 on 09/15/2025, at the facility, they failed to report the alleged abuse to CRU or law enforcement because Staff A was unaware of the regulatory requirement to report it, at that time. Staff A reported that the facility did not have a record to show that the facility had made a report to CRU or law enforcement about the alleged abuse.

In an interview on 10/03/2025 at 1:46 PM, Staff B, resident care coordinator, reported that when Staff C allegedly physically and verbally abused R1 on 09/15/2025, at the facility, they didn’t think the facility reported the alleged abuse to CRU or law enforcement. Staff B reported that they were not aware of the regulatory requirement to report the alleged abuse of R1 to CRU or law enforcement on 09/15/2025. Staff B reported that the facility did not have a record to show that the facility had made a report to CRU or law enforcement about the alleged abuse and that they had failed to follow through with appropriate reporting requirements in response to allegations that Staff C physically and verbally abused R1 on 09/15/2025.

In an interview on 10/03/2025 at 2:00 PM, Staff C, reported not knowing if the facility reported the abuse allegations, about them, towards R1, to CRU or law enforcement, at the time that the alleged abuse was alleged on 09/15/2025.

In an interview on 10/03/2025 at 2:33 PM, Collateral Contact 2 reported that the facility did not notify CRU of R1 allegedly being verbally and physically abused by Staff C on 09/15/2025 at the facility. CC2 reported that they felt the facility management was intentionally hiding it because they didn’t want to get in trouble.

In an interview on 11/20/2025 at 3:59 AM, Staff A reported that after Staff C allegedly physically and verbally abused R1 on 09/15/2025, at the facility, they were made aware, by the department on 10/02/2025, of their alleged failure to report the alleged abuse to CRU and law enforcement. Staff A reported that the facility will need to receive a citation since they failed to follow through with reporting requirements that regulation

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requires. Staff A stated that they hadn't done any official staff training on the failure yet, but they plan to now that the facility is receiving a citation.

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)_____ .

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

_____ _____

Administrator (or Representative) Date

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