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

FFII Olympia Tennant LLC
Fieldstone Cooper Point
810 Fieldstone Dr SW
Olympia, WA 98502

RE: Fieldstone Cooper Point License # 2688

Dear Administrator:

This letter addresses Compliance Determination(s) 70246 (Completion Date 12/16/2025) and 67736 (Completion Date 10/31/2025).

The Department completed a follow-up inspection of your Assisted Living Facility on 12/16/2025 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-2650-2, WAC 388-78A-2210-1, WAC 388-78A-2210-1-a, WAC 388-78A-2210-1-b

The Department staff who did the off-site verification:
Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

STATE OF WASHINGTON
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 the unannounced on-site full inspection on 10/28/2025 and 10/30/2025 of:

Fieldstone Cooper Point
810 Fieldstone Dr SW
Olympia, WA 98502

The following sample was selected for review during the unannounced on-site visit: 9 of 89 current residents and 0 former residents.

The department staff that inspected the Assisted Living Facility:

Anissa Bearden, Licensor
Celeste Vashey, ALF LTC Licensor

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

Statement of Deficiencies	License #: 2688	Compliance Determination # 67736
Plan of Correction	Fieldstone Cooper Point	Completion Date
Page 2 of 5	Licensee: FFII Olympia Tennant LLC	10/31/2025

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.

Clinton Fridley RN
Residential Care Services

11/05/2025
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)

11-8-25
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

This requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to immediately report to the department when the facility had smoke coming out of a resident's room which required implementation of their disaster plan for 1 of 1 assisted living facilities. This failure resulted in the department not being notified, as required, after implementing their disaster plan and placed all residents, staff and visitors at risk for harm due to delayed response and lack of situational awareness by support agencies.

Findings included...

Record review of the facility's Disaster and Emergency Manual, dated "2023", documented a disaster was an occurrence or situation causing destruction, distress, or threat to life and safety of one or more residents and personnel of the facility. The federal emergency management agency listed the following examples of possible disasters that included extreme heat, fires, and hazardous materials. Communication is a critical component of disaster and emergency preparedness and response. The disaster leader would take the lead role in communication with local, state, and or federal emergency services personnel.

In an interview on 10/29/2025 at 11:50 AM, Resident 10 (R10), reported there had been a fire in a resident's apartment a few months ago. R10 said the fire department arrived

at the facility.

Record review of the Department database on 10/29/2025 at 5:00 PM, documented there was no facility reported incidents related to any residents' oven smoking or a fire that resulted in the fire department coming to the facility and the implementation of the facility's fire disaster plan in the last six months.

In an interview on 10/30/2025 at 11:24 AM, Staff D, Caregiver, stated that approximately one month ago something caught fire in Resident 11 (R11)'s apartment oven. Staff D said due to the smoke R11 had to be evacuated from their apartment. Staff D said the other residents in the facility sheltered in place.

In an interview and observation on 10/30/2025 at 11:35 AM, Staff C, Senior Maintenance Director, stated that a few months ago a resident, who resided on the third floor, accidentally set their oven to the cleaning cycle. Staff C stated that the resident had items stored inside their oven which caused a lot of smoke to fill the room. Staff C stated they assumed there had been a lot of smoke because the fire department came and the smoke detector alarmed in the apartment. Staff C stated that the facility staff had to implement their disaster plan. Observation of the oven showed the front glass had been broken, that Staff C stated was done by the fire department. Inside the oven on the top rack, there were two metal pans stacked together and a pot with a black handle that had been heated and when Staff C touched it, the handle material crumbled. Inside the oven on the bottom were large amounts of a black chard substance.

In an interview on 10/30/2025 at 3:23 PM, Staff A, Executive Director, confirmed in the summertime R11's oven had been smoking and that the facility staff member pulled the fire alarm which resulted in the fire department coming to the facility. Staff A stated that they had to reeducate their facility staff on proper protocol because some facility staff knew the residents were to shelter in place whereas other facility staff tried to get the residents to start evacuating the building. Staff A stated they did not report the incident to the department hotline.

In an interview on 10/31/2025 at 3:45 PM, Staff A acknowledged that the facility staff implemented their disaster plan when the fire alarm was pulled and the fire department came to the facility and the residents had to shelter in place.

Statement of Deficiencies	License #: 2688	Compliance Determination # 67736
Plan of Correction	Fieldstone Cooper Point	Completion Date
Page 4 of 5	Licensee: FFII Olympia Tennant LLC	10/31/2025

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, Fieldstone Cooper Point is or will be in compliance with this law and / or regulation on (Date) 11-15-2025.

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

Administrator (or Representative) [signature] Date 11-8-25

WAC 388-78A-2210 Medication services.

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

(a) Meet the requirements of chapter 69.41 RCW Legend drugs Prescription drugs, and other applicable statutes and administrative rules; and

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

This requirement was not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents were administered their medications as ordered by their physician for 1 of 3 residents (Resident 9). This failure resulted in Resident 9 (R9) receiving medications outside of their physician orders and placed them at risk for medical complications.

Findings included...

Record review of the facility's policy titled, "Alteration in Residents Medications", dated 07/07/2017, documented it was the facility's policy to ensure residents receive their medications in a safe and prescribed manner.

Record review of R9's Service Plan Report, dated 08/08/2025, documented that R9 had moved into the facility on [redacted]/2022 with multiple medical diagnoses that included [redacted]. R9 required the facility staff to administer their medications, and the license nurse was to notify the physician with any concerns.

Record review of R9's Medication Administration Record (MAR), dated 09/01/2025

through 09/30/2025, documented that R9 had an order for midodrine take two times daily and to hold the medication if R9's systolic blood pressure (top number of the blood pressure reading) was greater than 130. Review of the administrations documented there were seven doses that were administered when R9's systolic blood pressure was greater than 130. There was no documentation for those seven doses that the medication was not given.

Record review of R9's MAR, dated 10/01/2025 through 10/29/2025, documented that R9 had an order for midodrine (a prescribed medication to treat low blood pressure) to take twice daily and to hold the medication if R9's systolic blood pressure was greater than 130. Review of the administrations documented there were six doses that were administered when R9's systolic blood pressure was greater than 130. There was no documentation for those seven doses that the medication was not given.

On 10/30/2025 at 2:00 PM, Staff B, Campus Director of Nursing Services, stated the residents MAR's were audited weekly for any gaps, timing, and discrepancies by Staff J, Assistant Director of Nursing. Staff B reviewed R9's MAR's and acknowledged that there were blood pressures that were above the physician prescribed parameters that R9's midodrine should have not been given.

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, Fieldstone Cooper Point is or will be in compliance with this law and / or regulation on (Date) 12-10-25 .

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

Administrator (or Representative) [signature] Date 11-8-25

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

FFII Olympia Tennant LLC
Fieldstone Cooper Point
810 Fieldstone Dr SW
Olympia, WA 98502

RE: Fieldstone Cooper Point # 2688

Dear Administrator:

The Department completed a full inspection of your Assisted Living Facility on 10/31/2025 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 many deficiency listed on the enclosed report; and
- May inspect your program 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 Return the Plan/Attestation Statement and report with signatures to:

Clinton Fridley, Adult Family Home Nurse Field Manager
Residential Care Services
Region 3, Unit E
Preferred methods:

eFax: (360) 992-7969
Email: rcsregion3email@dshs.wa.gov
Optional method:
800 NE 136th Ave Ste 200
Vancouver, WA 98684

• 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-2320 Intermittent nursing services systems.

(1) When an assisted living facility provides intermittent nursing services to any resident, either directly or indirectly, the assisted living facility must:

(b) Ensure the requirements of chapters 18.79 RCW and 246-840 WAC are met.

Based on interview and record review 3 of 3 residents showed the residents were not reviewed by the Registered Nurse delegator every 90 days. The facility identified the concern and the Registered Nurse delegator reviewed the residents that were over the 90 day review on 10/29/2025. The deficiency was corrected by the exit conference on 10/30/2025.

WAC 388-78A-2230 Medication refusal.

(1) When a resident who is receiving medication assistance or medication administration services from the assisted living facility chooses to not take his or her medications, the assisted living facility must:

(c) Notify the physician of the refusal and follow any instructions provided, unless there is a staff person available who, acting within his or her scope of practice, is able to evaluate the significance of the resident not getting his or her medication, and such staff person;

(i) Conducts an evaluation; and

(ii) Takes the appropriate action, including notifying the prescriber or primary care practitioner when there is a consistent pattern of the resident choosing to not take his or her medications.

Based on interview and record review 1 of 9 residents reviewed had refused their medication daily for two months and their physician had not been notified. The facility identified the concern, notified the physician of the refusals, received new order to discontinue the medication, and educated the medication technicians of the procedure when a resident refused their medication. The deficiency was corrected by the exit

conference on 10/30/2025.

WAC 388-78A-2610 Infection control.

(2) The assisted living facility must:

(c) Maintain and provide staff persons with the necessary training, supplies, equipment, and personal protective equipment for preventing and controlling the spread of infections by:

(ii) Ordering supplies when necessary.

(d) Provide all resident care and services according to current acceptable standards for infection control;

Based on observation, interview, and record review 1 of 1 facility's reviewed, the facility did not provide facility staff proper hand washing supplies in resident care areas when their hands were visibly soiled. The facility identified the concern and had hand washing supplies in all resident care areas. The deficiency was corrected by the exit conference on 10/30/2025.

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 (360)450-1218.

Sincerely,

Clinton Fridley RN

Clinton Fridley, Adult Family Home Nurse Field Manager

Region 3, Unit E
Residential Care Services

Enclosure

PLAN OF CORRECTIONS

Community Name: Cooper Point Olympia **Survey/Investigation Date:** 10/31/2025

Plan of Correction

Regulation #	Deficient System or Standard	Action Plan	Team Member's Name	Estimated date of completion	Signature/Date
WAC 388-78A-2210	A assisted living facility providing medication services either directly or indirectly, must: a) Meet the requirements of 69.41 RCW legend drugs. Prescription drugs, and other applicable statues and administrative rules. b) Develop and Implement systems that support and promote safe medication service for each resident.	Inservice about parameters, the importance of parameters and what steps must be taken when a medication is out of parameters in accordance with the order. All orders with parameters were reviewed Parameters audit will be conducted weekly	Rachael Kendall Executive Director Stanley Greene Director of Nursing Amy Lantry Resident Care Coordinator	12/10/25	RK 11-14-25

FIELDSTONE COMMUNITIES

PLAN OF CORRECTIONS

WAC 388-78A-2650	Reporting fires and incidents. The assisted living facility must immediately Report to the department of aging and disability services administration: Any unusual incident that required implementation of the assisted living facility's disaster plan including evacuation of all or part of the residents to another area of the assisted living facility or to another address	**Inservice on reporting to state when Disaster plan initiated when residents are to shelter in place.** **Will report to state in the event that disaster plan is initiated when resident are to shelter in place.**	Rachael Kendall Executive Director	11/15/2025	11-14-25

FIELDSTONE COMMUNITIES