

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Hearthstone Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 E. Barnett Road Medford, OR 97504	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were treated with respect and dignity for 1 of 3 residents (#22) reviewed for dignity. This placed residents at risk for being treated in an undignified manner. Findings include:</p> <p>Resident 22 admitted to the facility in 5/2024, with diagnoses including hemiplegia and adult failure to thrive.</p> <p>A 5/18/24 Late Entry Progress Note indicated Resident 22 worked with Staff 29 (Certified OT Assistant) in her/his room when bickering between them was observed because Resident 22 did not want to do the arm exercise. The resident indicated her/his arm hurt and persisted that she/he did not want to use the machine. The observing nurse entered the room to inform Staff 29 the resident was refusing and to disconnect the machine.</p> <p>The 5/18/24 Grievance Form indicated on 5/18/24 Resident 22 got upset with Staff 29 when Staff 29 did not want to stop the TENS (a battery-powered device with electrodes that deliver electrical impulses through the surface of our skin) unit because it hurt the resident. Staff 21 (Former LPN) intervened, told Staff 29 to stop and informed Staff 29 the resident had a right to stop the treatment. Later in the therapy session Resident 22 felt Staff 29 was rough with her/him and hurt her/him at least three times. Resident 22 stated Staff 29 needed to listen to her/him. The resident statement indicated at one time the resident told Staff 29 she/he would hit her if she hurt her/him. Staff 29 replied that would be assault and would press charges if she was hit. Staff 29 received education on the company ethics policy and utilizing clinical judgement appropriately during all treatment sessions.</p> <p>On 5/28/24 Resident 22 stated Staff 29's behavior was very unprofessional and rude and while she/he preferred not to work with her again, she would if she were the only therapist available.</p> <p>On 5/28/24 Staff 29 was unavailable to interview.</p> <p>On 5/28/24 at 12:10 PM, Staff 2 (Regional Director of Clinical) stated Staff 29 was suspended pending an investigation but then resigned. Staff 2 acknowledged Staff 29 did not treat Resident 22 with dignity and respect.</p>

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
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to ensure residents were free from sexual abuse for 2 of 5 sampled residents (#s 15 and 16) reviewed for abuse. This failure, determined to be an immediate jeopardy situation, placed residents at risk for sexual abuse when staff witnessed repeated intimate nonconsensual sexual activity without completing assessments to determine ability to consent and without putting appropriate interventions in place. Findings include:</p> <p>The facility's 3/2023 facility Freedom from Abuse, Neglect and Exploitation policy indicated the following:</p> <ul style="list-style-type: none"> - The facility will provide a safe resident environment and protect residents from abuse . this includes freedom from . sexual or physical abuse. - Sexual abuse is defined as non-consensual sexual contact of any type with a resident. - When abuse has been identified the facility is to take appropriate steps . to protect residents from additional abuse immediately which includes steps to prevent further potential abuse. - Report allegation to appropriate authorities within required timeframe's and conduct a thorough investigation. - Sexual abuse is indicated as non-consensual sexual contact of any type with a resident who appears to want the contact to occur but lacks the cognitive ability to consent. - Investigations of an allegation of sexual abuse will start with a determination of whether the sexual activity was consensual or not, taking into consideration the cognitive ability of the resident to consent. - Resident without cognitively ability to consent will not engage in sexual activity. - If a resident has a legal representative, the facility will ascertain which decisions the representative has the right to make, including consent for sexual activity. <p>Resident 15 admitted to the facility in 2019, with diagnoses including cognitive communication deficit, vascular dementia and a stroke.</p> <p>Resident 15's 2/16/24 Quarterly MDS indicated severe cognitive impairment.</p> <p>Resident 15's clinical record indicated she/he was her/his own responsible party and Witness 2 (family friend) as the resident's responsible party and POA (Power of Attorney) of financial.</p> <p>Resident 16 admitted to the facility in 2022, with diagnoses including a stroke. Resident 16's 9/16/22 Admission MDS indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident 16's clinical record indicated she/he was her/his own responsible party and Witness 1 (family member) as first emergency contact.</p> <p>A review of Resident 15 and Resident 16's Progress Notes from 5/19/24 through 5/21/24 revealed the following:</p> <ul style="list-style-type: none"> - 5/19/24 Staff 6 (PT) found Resident 15 in the common area touching Resident 16 inappropriately. Staff 6 reported the details to Staff 7 (RN). Both residents were separated. Using Google translate, Resident 16 was asked if she/he allowed Resident 15 to touch her/him and indicated, yes. Nursing staff contacted both the unit manager and administrator. The note further indicated the encounter was investigated by management and the interaction was consensual. - On 5/20/24 at 11:19 AM, Staff 7 found Resident 15 and Resident 16 in the dining room touching each other. Both residents were educated they could not do it there as it was a public place. The note indicated the administrator was aware. - On 5/20/24 at 5:50 PM, Staff 8 (LPN) witnessed Resident 15 and Resident 16 in the front lobby. Both residents had their hands under clothing and touching groin and chest areas, kissing. Both residents were separated. Resident 15 was asked about the touching and the resident was unable to recall and had no memory of the incident. The administrator was contacted. Staff 8 noted neither [resident] can consent, and it was not the first time the behavior was witnessed. - On 5/20/24 at 7:44 PM, Staff 8 indicated he spoke with Staff 1 (Administrator) and Staff 1 stated he investigated, and ruled out abuse. Staff 8 indicated Staff 1 asked him if it was reported to the State. Staff 8 contacted Witness 3 (Resident 15's family) and informed him the administrator investigated the 2 previous incidents and ruled out abuse, per [Staff 1's] request. - On 5/21/24 at 9:54 AM and 9:58 AM, Staff 15 (Social Services) spoke with Resident 15 and Resident 16 about the interactions. Resident 15 stated interaction was consensual. Resident 16 was asked via Google translate and she/he stated the touching was, ok. - On 5/21/24 at 4:49 PM, the physician was notified and after further review the touching was consensual. <p>Resident 15's Care Plan updated 5/21/24 indicated the resident engaged in intimate behaviors with another resident. Interventions included to encourage the resident to refrain from intimate expressions in public areas and guide the resident and her/his partner to a private room when intimate activity was desired.</p> <p>Resident 16's Care Plan updated 5/21/24 indicated the resident had a history of flirtatious behavior toward men. Interventions included to encourage the resident to refrain from intimate expressions in public areas and guide the resident and her/his partner to a private room when intimate activity was desired.</p> <p>A review of Resident 15 and Resident 16's clinical record from 5/19/24 through 5/21/24 revealed the following:</p> <ul style="list-style-type: none"> - A 5/21/24 cognitive evaluation for Resident 15 indicated moderate cognitive impairment. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<ul style="list-style-type: none"> - No updated cognitive evaluation was completed for Resident 16. - Resident 15 and Resident 16's physician was not contacted until 5/21/24 and only indicated the one incident on 5/19/24 was reported. - Care Plan revisions did not reflect both residents' cognitive impairment and the ability to consent to sexual intimacy. - No monitoring was in place to protect the residents' from further incidents. - Resident 15's responsible party (Witness 2) was not notified of the incidents. - Resident 16's family (Witness 1) was not contacted until 5/21/24. - There was no investigation conducted related to the three incidents on 5/19/24 and 5/20/24. - No facility sexual consent assessment was found for Resident 15 and Resident 16. - The State Survey Agency was not contacted until 5/21/24 at 3:42 PM, which only indicated the one incident on 5/19/24. <p>Interviews conducted with Resident 15, Resident 16 and Witnesses indicated the following:</p> <ul style="list-style-type: none"> - On 5/22/24 at 1:23 PM Resident 15 stated she/he did not believe she/he was in a relationship with another resident. Resident 15 stated she/he did not go around kissing anybody, and was not aware of touching or being intimate with another resident. Resident 15 stated it would not be ok with her/him if she/he was kissing another resident even if she/he liked another resident. - On 5/22/24 at 2:12 PM Resident 16 was interviewed with the assistance of Witness 1 providing translation. Resident 16 stated she/he had a boyfriend and she/he touched and kissed her/him. Resident 16 was unable to state the other resident's name and laughed and giggled throughout the interview. - On 5/22/24 at 12:41 PM and 2:32 PM Witness 1 (Resident 16's family member) stated the facility contacted her on 5/21/24. Witness 1 stated she was told Resident 16 engaged in inappropriate behavior in the hallway with another resident. Witness 1 stated the facility used Goggle translate to communicate to Resident 16 and stated Google translate did not always translate correctly. Witness 1 stated ever since Resident 16 had a stroke, the resident's family made the decisions about her/his care. Witness 1 stated Resident 16 was not her/himself and was not able to state what she/he wanted and had difficulty communicating. Witness 1 stated Resident 16 was not capable of making decisions related to sexual intimate behaviors and it was common sense (resident was cognitively impaired). Witness 1 stated Resident 16 may have said, yes at the moment and laugh but was not able make any real decisions. Witness 1 stated she was shocked, and it was not culturally appropriate for Resident 16 to engage in intimate behaviors in public. Witness 1 stated the facility did not ask the family if they agreed with Resident 16 engaging in the intimate behaviors with another resident. Witness 1 stated the resident's family did not give permission for Resident 16 to engage in intimate behaviors. <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- On 5/22/24 at 12:21 PM, Witness 3 (Resident 15's family member) stated the facility contacted him for the first time on 5/21/24 regarding the identified incidents. Witness 3 stated he was informed the intimate acts with Resident 15 occurred a few times, and was taken aback. Witness 3 stated Resident 15's conduct was out of character and was not aware the incidents took place in public areas. Witness 3 stated the facility informed him the incidents were consensual and he was very surprised. Witness 3 stated he agreed it was appropriate to keep both residents separated. Witness 3 further stated Witness 2 should have been contacted as well as she was Resident 15's POA and responsible party.</p> <p>- On 5/22/24 at 3:13 PM, Witness 2 (Responsible party) stated she was the responsible party for Resident 15. Witness 2 stated Witness 3 was also involved with Resident 15's care. Witness 2 stated she was not aware nor contacted about any of the identified incidents between Resident 15 and Resident 16 and expected the facility to contact her about the incidents. Witness 2 stated she was surprised and could not imagine Resident 15 engaging in intimate acts. Witness 2 stated she did not believe Resident 15 was cognitively able to consent as Resident 15 had multiple strokes and seizures. Witness 2 stated due to Resident 15's cognitive impairments, she/he was extremely suggestible to others influences. Witness 2 stated Resident 15 was unable to make her/her own decisions and her/his, logic went away a long time ago. Witness 2 further stated the intimate acts Resident 15 engaged in was out of character and she did not approve of the behaviors.</p> <p>Interviews conducted with facility Staff revealed the following:</p> <p>- On 5/21/24 at 12:40 PM, Staff 12 (CMA) stated she was aware of Resident 15 and Resident 16 being found together two to three times. Staff 12 stated she believed Resident 15 was not cognitively able to consent and was not sure about Resident 16 due language barrier.</p> <p>- On 5/21/24 at 1:14 PM, Staff 14 (CNA) stated she regularly cared for Resident 15. Staff 14 stated Resident 15 was confused and Resident 16 seemed with it. Staff 14 stated she did not witness any of the incidents but was aware they were found together a few times.</p> <p>- On 5/21/22 at 1:46 PM, Staff 5 (LPN) stated on 5/19/24 a sexual incident between Resident 15 and Resident 16 was observed by Staff 6 (PT) and was reported to her. Staff 5 stated two more incidents between Resident 15 and Resident 16 occurred on the morning and evening of 5/21/24. Staff 5 stated Staff 8 (LPN) called Resident 15's family and was told by Staff 1 (Administrator) to not report the incident to the State. Staff 5 stated she was not aware of either resident's family being contacted prior to the third incident. Staff 5 stated Resident 15 was alert and oriented to self only and Resident 16 was difficult to assess due to being non-English speaking. Staff 5 stated on 5/20/24 Staff 1 told staff to not worry about keeping the residents separate and the behavior was ok.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- On 5/21/24 at 3:47 PM, Staff 8 stated on the evening of 5/21/24 he was heading inside the facility and was able to see through the front window. Staff 8 stated he saw Resident 15 had her/hands under Resident 16's shirt and Resident 15 had her/his hand down Resident 16's pants, the residents were kissing. Staff 8 stated he asked staff what was going on and was told Staff 1 said it was ok for the behavior to occur. Staff 8 stated he spoke with Resident 15 about 10 minutes later after the incident and Resident 15 was unable to recall what happened. Staff 8 stated he believed it was best to keep the residents separated. Staff 8 stated he looked in the progress notes and read the same type of incident had occurred twice before. Staff 8 stated he contacted both Staff 1 and the unit manager. Staff 8 stated Staff 1 asked if he had reported the observed incident to the State. Staff 8 stated he told Staff 1 it was his responsibility to notify the State. Staff 8 stated he believed Resident 15 was not cognitively able to consent to sexual behaviors as the resident was not able to recall the incident that had just occurred. Staff 8 stated he was unsure if Resident 16 was able to consent due to the language barrier. Staff 8 stated he contact Resident 15's family and was told by Staff 1 to inform the family two investigations had been completed and no abuse was determined. Staff 8 stated he was not asked to write a statement regarding the incident he observed.</p> <p>- On 5/22/24 at 11:32 AM and 5/23/24 at 9:47 AM, Staff 7 (RN) stated on 5/19/24 she was informed by Staff 6 of a sexual incident between Resident 15 and Resident 16. Staff 7 stated on the morning of 5/21/24 she observed Resident 15 and Resident 16 in the dining room caressing each other. Staff 7 stated Resident 16 moved away once she called out the resident's name. Staff 7 stated she removed Resident 16 from the dining room. Staff 7 stated she was told by Staff 1 to direct the residents to a private area when the residents were observed engaging in intimate behaviors in public. Staff 7 stated Resident 16 was aware but confused about what she/he was doing. Staff 7 stated she was not sure if Resident 15 was able to consent. Staff 7 stated Resident 16's family made health-related decisions for her/him. Staff 7 stated she was not aware if the residents' families were contacted regarding the incidents. Staff 7 stated she was not asked to write a statement regarding the observed incident on the morning of 5/21/24 and was told to just make a progress note. Staff 7 stated nothing was in place regarding keeping Resident 15 and Resident 16 separated.</p> <p>- On 5/22/24 at 12:14 PM, Staff 6 (PT) stated on 5/19/24 she witnessed Resident 15 starting to lean into Resident 16 as if she/he was going to start kissing her/him. Staff 6 stated the residents were holding hands. Staff 6 stated Resident 16 had her/his right leg on the window seal with her/his legs open. Resident 15 had her/his other hand on Resident 16's groin area over the clothes. Staff 6 stated she wrote a statement, and it was given to administrative staff. Staff 6 stated she believed Resident 15 was able to understand to a certain extent. Staff 6 stated both residents kept seeking each other out.</p> <p>- On 5/21/24 at 12:40 PM and 5/22/24 at 12:59 PM, Staff 10 (CNA) stated she did not witness any of the incidents between Resident 15 and Resident 16 but was aware of the residents being caught together being intimate. Staff 10 stated she was not informed to keep both residents separated until Monday afternoon.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- On 5/22/24 at 3:45 PM, Staff 15 (Social Services) stated he was not notified of the incidents between Resident 15 and Resident 16 until 5/21/24. Staff 15 stated it was initially the residents' holding hands, then kissing and touching. Staff 15 stated he spoke with Resident 15 and the resident indicated she/he was comfortable with the kissing, and it was ok. Staff 15 stated he spoke with Resident 16 using Google translate and the resident indicated she/he was also ok with the incidents. Staff 15 stated Resident 16's family was not contacted until 5/21/24 and was told the behavior had not been seen before to contact the family if it occurred again. Staff 15 stated he did not contact Resident 15's family but nursing staff did. Staff 15 stated he believed Resident 15 was her/his own responsible party and Witness 2 was power of attorney for financial only. Staff 15 stated if Resident 15 was able to let staff know when she/he had to use the bathroom she/he was then able to consent to the touching. Staff 15 further stated Resident 16 was cognitively able to consent but was just not able to communicate due language barrier.</p> <p>- On 5/22/24 at 4:31 PM, Staff 9 (RN) stated she was often the nurse for Resident 15. Staff 9 stated Resident 15 had dementia and was not able to consent to any relationship or sexual encounter. Staff 9 stated she did not directly see any of the sexual incidents occur but stated she overheard a conversation of administrative staff directing staff to put minimal information on the residents' progress notes regarding the incidents.</p> <p>- On 5/23/24 at 12:46, PM Staff 16 (LPN) stated she knew the incidents between Resident 15 and Resident 16 was sexual abuse. Staff 16 stated she informed Staff 1 that the incidents needed to be reported the state but was not.</p> <p>On 5/22/24 at 6:07 PM, Staff 1 (Administrator) and Staff 2 (Regional Director of Clinical) were notified of the Immediate Jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to implement policies and procedures to prevent sexual abuse resulting in witnessed repeated non-consensual sexual activity without appropriate assessments to determine consent and interventions in place.</p> <p>On 5/23/24 at 10:50 AM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <p>*An investigation for the interaction between Resident 15 and Resident 16 was to be completed.</p> <p>*Staff 1 was provided education regarding abuse and reporting of abuse on 5/22/24. Staff 1 was removed as the abuse coordinator pending completion of the investigation.</p> <p>*Care Plans for Resident 15 and Resident 16 were updated to identify sexual behaviors and interventions to prevent ongoing sexual interactions. Interventions included monitoring of residents to ensure they do not engage in sexual behaviors including kissing and fondling, and redirection away if attempts at sexual behaviors are observed. Additional intervention included immediate notification of charge nurse. Who would notify the DON (Director of Nursing) and administrator.</p> <p>*DON was to complete baseline interview audit of all cognitively intact residents to ensure there are no additional residents who have experienced non-consensual sexual contact.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*DON would complete an interview audit of 15 staff members from various shifts and departments to ensure there has been no observed abuse in the past three months with cognitively intact and cognitively impaired residents.</p> <p>*DON was to provide education on active staff regarding abuse and reporting abuse.</p> <p>*Facility staff would be provided with information regarding who to contact if there was a lack of perceived response to reports of abuse from management at the facility level.</p> <p>*Audits would be conducted by DNS or designee weekly until substantial compliance was reached, then monthly for two months with verification of sustained compliance.</p> <p>*Audit trends would be reported to the facility QAPI for three months for review and further recommendations.</p> <p>*The Plan of Correction would be completed by 5:00 PM on 5/23/24.</p> <p>The IJ was removed on 5/28/24 at 3:58 PM, as confirmed by onsite verification by the survey team.</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>34324</p> <p>Based on interview and record review the facility administration failed to implement their abuse policy procedures in the areas of identification, investigation, protection, and reporting which resulted in repeated incidents of sexual abuse for 2 of 5 sampled residents (#s 15 and 16) reviewed for abuse. This failure to implement their abuse policy and procedures resulted in Resident 15 and Resident 16 repeatedly engaging in intimate nonconsensual sexual activity.</p> <p>The facility's 3/2023 Freedom from Abuse, Neglect and Exploitation policy including the Abuse Reporting and Responsibilities of Covered Individuals indicated the following:</p> <ul style="list-style-type: none"> - The facility will provide a safe resident environment and protect residents from abuse . this includes freedom from . sexual or physical abuse. - Report allegation to appropriate authorities within required timeframes and conduct a thorough investigation. - Investigations of an allegation of sexual abuse will start with a determination of whether the sexual activity was consensual or not, taking into consideration the cognitive ability of the resident to consent. - To ensure alleged violations involving abuse, neglect, exploitation or mistreatment, are reported and the results of the investigation of the allegations are reported within the prescribed timeframes. - The facility will report to the State Agency and law enforcement any reasonable suspicion of a crime against any individual who is a resident or who is receiving care from the facility within timeframes. - In response to allegations of abuse .the facility will report immediately but no later than 2 hours, all alleged violations involving abuse . - The facility will create an environment in which staff and others feel comfortable and safe in reporting potential violations or suspicions of potential violations. <p>Resident 15 admitted to the facility in 2019, with diagnoses including dementia.</p> <p>Resident 15's 2/16/24 Quarterly MDS indicated severe cognitive impairment. A Cognitive Evaluation completed on 5/21/24 indicated Resident 15 had moderate cognitive impairment.</p> <p>Resident 16 admitted to the facility in 2022, with diagnoses including stroke.</p> <p>Resident 16's 9/16/22 Admission MDS indicated severe cognitive impairment.</p> <p>A review of Resident 15 and Resident 16's progress notes from 5/19/24 through 5/20/24 revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<ul style="list-style-type: none"> - On 5/19/24 Staff 6 (PT) found Resident 15 in the common area touching Resident 16 inappropriately. Both the unit manager and administrator were notified. The note further indicated the encounter was investigated by management and the interaction was consensual. - On 5/20/24 at 11:19 AM Staff 7 (RN) found Resident 15 and Resident 16 in the dining room touching each other. Both residents were educated they could not do it there as it was a public place. The note indicated the administrator was aware. - On 5/20/24 at 5:50 PM Staff 8 (LPN) witnessed Resident 15 and Resident 16 in the front lobby. Both residents had their hands under clothing and touching groin and chest areas, kissing. The administrator was contacted. Staff 8 noted neither resident could not consent, and it was not the first time the behavior was witnessed. - On 5/20/24 at 7:44 PM Staff 8 indicated he spoke with Staff 1 (Administrator) and Staff 1 stated he investigated and ruled out abuse. Staff 8 indicated Staff 1 asked him if it was reported to the State. Staff 8 contacted Witness 3 (Resident 15's family) and informed him the administrator investigated the two previous incidents and ruled out abuse, per [Staff 1's] request. <p>A review of Resident 15 and Resident 16's clinical record from 5/19/24 through 5/21/24 revealed the following:</p> <ul style="list-style-type: none"> - No updated cognitive evaluation was completed for Resident 16. - Resident 15 and Resident 16's physician was not contacted until 5/21/24 and only indicated the one incident on 5/19/24. - No interventions were put in place to protect the residents from further incidents. - No thorough investigation was conducted related to the three incidents on 5/19/24 and 5/20/24. - No sexual consent assessment was completed for the residents. - No indication the State Survey Agency (SSA) was contacted until 5/21/24 at 3:42 PM, which only indicated the one incident on 5/19/24. <p>Interviews conducted with facility staff revealed the following:</p> <ul style="list-style-type: none"> - On 5/21/24 at 12:40 PM, Staff 12 (CMA) stated she was aware of Resident 15 and Resident 16 being found together two to three times. - On 5/21/24 at 1:14 PM, Staff 14 (CNA) stated she did not witness any of the incidents but was aware they were found together a few times. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Hearthstone Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 E. Barnett Road Medford, OR 97504	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- On 5/21/22 at 1:46 PM, Staff 5 (LPN) stated on 5/19/24 a sexual incident between Resident 15 and Resident 16 was observed by Staff 6 (PT) and was reported to her. Staff 5 stated two more incidents between Resident 15 and Resident 16 occurred on the morning and evening of 5/21/24. Staff 5 stated Staff 8 (LPN) called Resident 15's family and was told by Staff 1 (Administrator) to not report the incident to the state. Staff 5 stated on 5/20/24 Staff 1 told staff to not worry about keeping the residents separate and the behavior was ok.</p> <p>- On 5/21/24 at 3:47 PM, Staff 8 stated on the evening of 5/21/24 he saw Resident 15 had her/hands under Resident 16's shirt and Resident 15 had her/his hand down Resident 16's pants, the residents were kissing. Staff 8 stated he asked staff what was going on and was told Staff 1 said it was ok for the behavior to occur. Staff 8 stated he looked in the progress notes and read the same type of incident had occurred twice before. Staff 8 stated he contacted both Staff 1 and the unit manager. Staff 8 stated Staff 1 asked if he had reported the observed incident to the state. Staff 8 stated he told Staff 1 it was his responsibility to notify the state. Staff 8 stated he contact Resident 15's family and was told by Staff 1 to inform the family two investigations had been completed and no abuse was determined. Staff 8 stated he was not asked to write a statement regarding the incident he observed.</p> <p>- On 5/22/24 at 11:32 AM and 5/23/24 9:47 AM, at Staff 7 (RN) stated on the morning of 5/21/24 she observed Resident 15 and Resident 16 in the dining room caressing each other. Staff 7 stated she was told by Staff 1 to direct the residents to a private area when the residents were observed engaging in intimate behaviors in public. Staff 7 stated she was not asked to write a statement regarding the observed incident on the morning of 5/21/24 and was told to just make a progress note.</p> <p>- On 5/22/24 at 12:14 PM, Staff 6 stated on 5/19/24 she witnessed Resident 15 starting to lean into Resident 16 as if she/he was going to start kissing her/him. Staff 6 stated the residents were holding hands. Staff 6 stated Resident 16 had her/his right leg on the window seal with her/his legs open. Resident 15 had her/his other hand on Resident 16's groin area over the clothes. Staff 6 stated she wrote a statement, and it was given to administrative staff.</p> <p>- On 5/21/24 at 12:40 PM and 5/22/24 at 12:59 PM, staff 10 (CNA) stated she did not witness any of the incidents between Resident 15 and Resident 16 but was aware of the residents being caught together being intimate.</p> <p>- On 5/22/24 at 3:45 PM, Staff 15 (Social Services) stated he was not notified of the incidents between Resident 15 and Resident 16 until 5/21/24. Staff 15 stated if Resident 15 was able to let staff know when she/he had to use the bathroom she/he was then able to consent to the touching.</p> <p>- On 5/22/24 at 4:31 PM, Staff 9 (RN) stated she was often the nurse for Resident 15. Staff 9 stated she did not directly see any of the sexual incidents occur but stated she overheard a conversation of administrative staff directing staff to put minimal information on the residents' progress notes regarding the incidents.</p> <p>- On 5/23/24 at 12:46 PM, Staff 16 (LPN) stated she knew the incidents between Resident 15 and Resident 16 was sexual abuse. Staff 16 stated she informed Staff 1 that the incidents needed to be reported the state but was not.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>- Staff 1 was not able to be interviewed due to being play on administrative leave pending facility investigation.</p> <p>- On 5/22/24 at 9:06 AM, Staff 2 (Regional Director of Clinical) acknowledged the sexual incidents between Resident 15 and Resident 16 was not reported to the State timely for the three identified incidents and stated she anticipated the citation.</p> <p>On 5/23/24 at 3:09 PM, Staff 17 (Regional Director of Clinical) was notified of the Immediate Jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to implement their abuse policy procedures in the areas of identification, investigation, protection, and reporting which resulted in repeated incidents of sexual abuse between Resident 15 and Resident 16.</p> <p>On 5/23/24 at 4:34 PM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <ul style="list-style-type: none"> *Investigation for interaction between Resident 15 and Resident 16 was to be completed. *The 5/19/24 contact between Resident 15 and Resident 16 was reported to DHS on 5/21/24. * The Facility administrator was provided education regarding abuse and reporting of abuse on 5/22/24 and has been removed as the abuse coordinator pending completion of the investigation. * The Care Plans for Resident 15 and Resident 16 would be updated to identify sexual behaviors and interventions to prevent ongoing sexual interactions. Initial interventions were to include monitoring of resident(s) to ensure that they did not engage in sexual behaviors including kissing and fondling, and re-direction away if attempts at sexual behaviors such as touching or fondling were observed. Additional intervention included immediate notification of charge nurse, who would subsequently notify the DON and administrator. *The DON (Director of Nursing)/Designee would complete a baseline interview audit of all cognitively intact residents to ensure there were no additional residents who had experienced non-consensual sexual contact. *The DON/Designee would complete an interview audit of 15 staff members from various shifts and departments to ensure that there were no observations of abuse in the past 3 months with cognitively intact or cognitively impaired residents. *The DON/Designee would provide education to all scheduled and PRN staff not currently on a leave of absence on abuse and guidelines for reporting abuse. *Facility staff would be provided with information regarding who to reach out to at a higher management level if there is a perceived lack of response to reports of abuse from management at the facility level. *Audits would be conducted by DON or designee weekly until substantial compliance is reached, then monthly for 2 months with verification of sustained compliance. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*Audit trends would be reported to facility QAPI for 3 months for review and further recommendations.</p> <p>*The Plan of Correction would be completed by 10:00 AM on 5/24/24.</p> <p>The IJ was removed on 5/28/24 at 3:58 PM, as confirmed by onsite verification by the survey team.</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179</p> <p>1. Based on interview and record review it was determined the facility failed to obtain treatment orders, failed to administer timely treatment, and failed to provided correct treatment for a surgical wound for 1 of 7 sampled residents (#6) reviewed for wounds. This failure, determined to be an immediate jeopardy situation, resulted in Resident 6 experiencing a delay in wound care treatment which resulted in the resident's wound to become infected and dehisced (separation of the wound due to improper healing). Resident 6 was re-hospitalized and required surgery for an above the knee amputation (AKA). Findings include:</p> <p>Resident 6 admitted to the facility on [DATE] with diagnoses of aftercare of the surgical right below the knee amputation and stroke.</p> <p>The 4/22/24 Admission Orders revealed no wound care orders for the right below the knee amputation (BKA).</p> <p>The 4/22/24 Skin Evaluation revealed the surgical wound measured 9.32 cm x 2.19 cm and had 30 staples. The wound was covered with xeroform (wound dressing) and kerlix (gauze wrapping) and the dressing was clean, dry and intact.</p> <p>There was no evidence in the medical record any staff from the facility clarified with the physician the lack of wound care orders or requested wound care orders until 4/29/24, seven days after the resident's admitted .</p> <p>On 4/29/24 wound care orders were received to cleanse the right stump with wound cleanser, pat dry, apply xeroform and an ABD (a gauze dressing that absorbs liquid from large, heavily draining wounds) and then wrap with kerlix and then an ACE wrap. This was to be completed every day.</p> <p>The 4/30/24 Skin Evaluation revealed the surgical wound measured 11.07 cm x 2.51 cm and indicated that no treatment was in place.</p> <p>The 4/2024 TAR revealed wound care to the right BKA was initiated on 4/30/24; eight days after admission to the facility.</p> <p>The 5/1/24 Progress Note revealed Resident 6's surgical wound staples were removed and replaced with steri-strips (strips of surgical tape used to close up wounds) and the right stump was redressed per treatment orders.</p> <p>The 5/2/24 Wound Consultant Note revealed Resident 6's wound measured 11.0 cm x 3.0 cm and had a scant amount of serosanguinous exudate (bloody and yellowish liquid drainage from a wound).</p> <p>The 5/4/24 Progress Notes revealed Resident 6's wound dressing was saturated and removed. There were no steri strips on the wound, the wound edges were no longer approximated (close together) and the wound opened about an inch and a half. The resident was transferred to the hospital to be evaluated by a physician.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The 5/4/24 Hospital Records revealed Resident 6's wound dehisced and there was concern of infection. The wound was irrigated (washed out), debrided (unhealthy skin removed) and a Wound Vac (Vacuum-assisted closure, a method to decrease air pressure around a wound to assist the healing) was applied.</p> <p>The 5/15/24 Hospital Discharge Summary revealed Resident 6 underwent a surgical right AKA on 5/7/24, three days after the resident was admitted .</p> <p>On 5/22/24 at 11:50 AM, Staff 4 (Unit Manager) acknowledged Resident 6 admitted to the facility with no wound care orders and did not receive any wound treatments from 4/22/24 through 4/30/24. Staff 4 stated if a resident admitted with a wound and no wound care orders, the staff should clarify and obtain the needed wound care orders. Staff 4 verified Resident 6's wound got infected, dehisced, and the resident was transferred back to the hospital where she/he had a right AKA.</p> <p>On 5/22/24 at 11:53 AM and 5/26/24 at 1:55 PM, Staff 19 (LPN) stated when she admitted Resident 6 to the facility she asked another staff member to obtain wound treatment orders since Resident 6 did not admit with any. Staff 19 further stated the wound got infected due to lack of wound care the first week and because Staff 21 (Former LPN) put calcium alginate (wound packing dressing used to absorb heavy drainage) all over the wound which caused the wound to deteriorate. Staff 19 stated she reported the calcium alginate incident to Staff 3 (DNS).</p> <p>On 5/22/24 at 1:34 PM, Staff 3 stated she could not recall when she was notified of the calcium alginate incident or how she responded.</p> <p>Staff 21 was unable to be interviewed.</p> <p>On 5/22/24 at 3:25 PM, Staff 1 (Administrator) and Staff 2 (Regional Director of Clinical) were notified of the Immediate Jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to obtain wound treatment orders, provide timely treatment to a wound and administer incorrect treatment.</p> <p>On 5/23/24 at 8:38 AM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <ul style="list-style-type: none"> *Facility would verify wound treatments were in place for Resident 6. *A baseline audit of all residents to ensure there were no unidentified wound areas. *A baseline audit of residents with current wounds would be completed to ensure treatment orders were in place. *All licensed nurse staff would receive education regarding initiation of treatment orders for new admits with identified skin impairments and facility acquired skin impairments. *Weekly audits would be conducted for four weeks, then monthly for two months. *Audit trends would be reported to the facility QAPI for three months for review and further recommendations. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>*The Plan of Correction would be completed by 2:00 PM on 5/23/24.</p> <p>The IJ was removed on 5/28/24 at 3:58 PM, as confirmed by onsite verification by the survey team.</p> <p>2. Based on interview and record review it was determined the facility failed to follow physician orders related to fluid restriction and wounds for 1 of 4 sampled residents (#20) reviewed for physician orders. This placed residents at risk for fluid overload. Findings include:</p> <p>a. Resident 20 admitted to the facility in 6/2022 with diagnoses including heart failure.</p> <p>The 4/12/24 Hospital Re-Admission Order's revealed an order to restrict fluids to 2,000 ml/day.</p> <p>The 4/21/24 through 5/20/24 Point of Care Fluid Intake documentation revealed Resident 20 exceeded her/his fluid restriction 21 of the 30 days reviewed.</p> <p>On 5/23/24 at 9:20 AM, Resident 20 declined to be interviewed.</p> <p>On 5/23/24 at 9:31 AM, Staff 22 (CNA) stated the resident did not follow the fluid restriction and consistently drank 1800 ml or more on day shift. Staff 22 stated she might remind the resident of the fluid restriction once a week.</p> <p>On 5/23/24 at 9:36 AM, Staff 20 (LPN) stated the resident was often not truthful about how much she/he drank and she did not report to the physician when she/he exceeded the fluid restriction.</p> <p>On 5/23/24 at 9:44 AM Staff 4 (Unit Manager) verified the facility did not follow the physician order for the 2,000 ml/day fluid restriction.</p> <p>34324</p> <p>b. Resident 18 admitted to the facility in 2018 with diagnoses including non-pressure chronic ulcers.</p> <p>A 5/4/24 physician order indicated Resident 18 was to receive wound care to the left lower extremity. Abrasions were to be cleansed with wound cleanser, xerofoam (wound dressing) was to be applied to the open areas, covered with an ABD pad (a gauze dressing that absorbs liquid from large or heavily draining wounds) and wrapped with Kerlix every other day.</p> <p>The 5/2024 TAR indicated the treatment to the left lower extremity was checked as completed on 5/18/24 by Staff 4 (RN Unit Manager).</p> <p>A progress note dated 5/19/24 indicated the dressing on the Resident 18's left lower extremity was not completed on 5/18/24.</p> <p>On 5/22/24 at 11:32 AM, Staff 7 (RN) stated she wrote the progress note on 5/19/24. Staff 7 stated Resident 18 was to receive dressing treatments every other day. Staff 7 stated on 5/19/24 she noticed the dressing was not changed for Resident 18 as the dressing had the date of 5/16/24 with her initials.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 5/23/24 at 11:14 AM, Staff 4 (RN Unit Manager) stated he worked the floor on 5/18/24 and was assigned to Wing 1 as the nurse. Staff 4 stated his duties as the nurse included completing treatments. Staff 4 stated he, did not get to those [treatments] on 5/18/24 due to being busy. Staff 4 acknowledged he did not complete the treatment for Resident 18 on 5/18/24 but marked it on the TAR as being completed.</p> <p>c. Resident 19 admitted to the facility in 2022 with diagnoses including a non-pressure chronic ulcer.</p> <p>A 5/2/24 physician order indicated Resident 19 was to receive daily wound treatments to the left foot. The wound was to be cleansed with wound cleanser, pat dried with collagen and wound gel applied.</p> <p>The 5/2024 TAR indicated the treatment to Resident 19's left foot was not completed on 5/17/24 and checked as completed on 5/18/24 by Staff 4 (RN Unit Manager).</p> <p>A progress note dated 5/19/24 indicated Resident 19 reported to Staff 7 (RN) her/his dressing to the left foot was not completed on 5/17/24 and 5/18/24.</p> <p>On 5/22/24 at 11:32 AM Staff 7 (RN) stated she wrote the progress note on 5/19/24 for Resident 19. Staff 7 stated Resident 19 was to receive daily wound treatments to the left foot. Staff 7 stated Resident 19's dressing still had the date of 5/16/24 with her initials. Staff 7 stated Resident 19 also informed her treatment was not completed.</p> <p>On 5/22/24 at 7:14 PM Resident 19 stated her/his treatment to the left foot was to be completed daily. Resident 19 stated her/his treatment was not completed on 5/17/24 and 5/18/24. Resident 19 stated Staff 7 noticed the treatment was not completed, and she/he told Staff 7 it was not completed.</p> <p>On 5/23/24 at 11:14 AM Staff 4 (RN Unit Manager) stated he worked the floor on 5/18/24 and was assigned to Wing 1 as the nurse. Staff 4 stated his duties as the nurse included completing treatments. Staff 4 stated he did, did not get to those [treatments] on 5/18/24 due to being busy. Staff 4 acknowledged he did not complete the treatment for Resident 19 on 5/18/24 but marked it on the TAR as being completed.</p> <p>On 5/23/24 at 12:46 PM Staff 16 (LPN/MDS Coordinator) stated she worked the floor on 5/17/24 and was assigned to Wing 1. Staff 16 stated her duties as the nurse included completing treatments. Staff 16 stated she did not complete the wound treatment for Resident 19 because the resident was up, and she did not want to interrupt the resident's social interactions. Staff 16 stated the treatment on the TAR for Resident 19 was left blank to alert the next nurse the treatment needed to be completed. Staff 16 acknowledged the treatment for Resident 19 on 5/17/24 was not completed.</p> <p>Staff 9 was unable to be interviewed.</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33179</p> <p>Based on interview and record review it was determined the facility failed to comprehensively assess, monitor, treat and follow physician orders for pressure ulcer treatment for 1 of 7 sampled residents (#4) reviewed for pressure ulcers. This failure, determined to be an immediate jeopardy situation, resulted in Resident 4's Stage 2 (partial thickness skin loss) pressure ulcer observed upon admission which worsened to an infected, unstageable (full thickness tissue loss where the depth of the wound is obscured by non-viable or dead tissue) pressure ulcer. Resident 4 was admitted to the hospital where she/he required surgical debridement (the removal of damaged tissue from the wound). Findings include:</p> <p>Resident 4 admitted to the facility on [DATE] with diagnoses including heart failure, hemiplegia and non-pressure chronic ulcer of skin of other sites with necrosis (tissue death) of muscle.</p> <p>The 2/26/24 Admission Nursing Database indicated Resident 4 had multiple skin concerns including a pressure wound on the sacrum. The assessment further indicated the resident was confused and required extensive to total assistance by one to two staff members to turn and reposition in bed. The pressure ulcer assessment did not include measurements, staging, or characteristics of the wound.</p> <p>The 2/26/24 Admission Orders for Resident 4's sacrum wound included: cleanse with normal saline, pat dry, apply calcium alginate (wound dressing) to the wound bed and cover with foam daily.</p> <p>The 2/27/24 Progress Note revealed Resident 4 had a pressure ulcer on her/his sacrum.</p> <p>The 2/2024 TAR revealed no treatments were completed for Resident 4's sacrum wound from 2/26/24 through 2/29/24.</p> <p>The 3/2024 TAR revealed no sacral treatments were completed for Resident 4 from 3/1/24 through 3/6/24, until new orders were initiated on 3/7/24.</p> <p>The 3/11/24 Progress Note revealed eschar (nonviable tissue) and slough (dead tissue) were present on the sacrum wound.</p> <p>The 3/14/24 Pressure Ulcer Care Plan incorrectly documented the pressure ulcer as an unstageable [NAME] (pressure ulcer that arises within hours/days of death) Ulcer.</p> <p>The 3/20/24 Skin/Wound Evaluation revealed Resident 4's sacrum wound measured 4.91 cm x 3.17 cm x 2 cm. The assessment indicated the wound had deteriorated, was infected and assessed to be an unstageable ulcer due to slough and/or eschar. This was the first comprehensive wound assessment to include wound measurements, staging and wound characteristics.</p> <p>The 3/24/24 Progress Note indicated the sacrum wound continued to decline and the on-call provider was notified.</p> <p>The 3/27/24 Physician Note revealed the resident was referred to the wound clinic.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The 3/28/24 Skin/Wound Evaluation revealed the sacrum wound measured 5.36 cm x 3.26 cm x 2.2 cm. The wound had deteriorated and there was evidence of infection. There was redness and inflammation around the wound, and light exudate (drainage) with moderate odor. The physician was notified.</p> <p>The 4/2024 TAR revealed no sacrum wound treatments were completed.</p> <p>The 4/2/24 Wound Consultant notes indicated on initial exam Resident 4's sacrum wound deteriorated with severe worsening.</p> <p>The 4/3/24 Skin/Wound Evaluation revealed the resident's wound measured 6.98 cm x 6.42 cm x 3.4 cm. The wound bed was 60% slough, had moderate drainage and a strong odor. The wound had deteriorated and the provider was notified.</p> <p>The 4/3/24 Progress Note revealed the resident had a change of condition related to blood in the urine and low blood pressure; the resident was transferred to the hospital.</p> <p>The 4/22/24 Hospital Records indicated Resident 4 was transferred to the hospital on 4/3/24 for blood in her/his urine and signs of infection in the sacrum wound. Resident 4 was diagnosed with an urinary tract infection, pneumonia and an infected sacral pressure ulcer with osteomyelitis (bone infection) which resulted in surgical debridement. Per the hospital records, after the surgical debridement the ulcer was identified as a Stage IV (full thickness skin loss) pressure ulcer.</p> <p>On 5/21/24 at 11:44 AM, Witness 5 (Previous Facility-Care Manager) stated Resident 4 discharged from their facility on 2/26/24 with a Stage 2 pressure ulcer to her/his coccyx with wound treatment orders.</p> <p>On 5/22/24 at 11:35 AM, Staff 4 (Unit Manager) verified the facility did not follow the admission physician wound care orders, did not treat the wound until 3/7/24, did not monitor or assess the wound until 3/20/24 and stopped treatment on 4/1/24. Staff 4 verified the facility incorrectly identified Resident 4's pressure ulcer as a [NAME] Ulcer.</p> <p>On 5/22/24 at 11:55 AM, Staff 19 (LPN) stated Resident 4's pressure wound was fist sized and she could smell the wound when she entered the room on 4/3/24. Staff 19 stated Resident 4's wound was not a [NAME] Ulcer.</p> <p>On 5/22/24 at 3:25 PM, Staff 1 (Administrator) and Staff 2 (Regional Director of Clinical) were notified of the Immediate Jeopardy (IJ) situation and provided a copy of the IJ template related to the facility's failure to assess, monitor and treat Resident 4's Stage 2 pressure ulcer and as a result worsened to a Stage 4 pressure ulcer.</p> <p>On 5/23/24 at 8:38 AM, an acceptable facility IJ removal plan was submitted by the facility. The plan indicated the facility would implement the following actions:</p> <p>*Resident 4 was discharged .</p> <p>*A baseline audit of all residents would be completed to ensure there were no unidentified wounds.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Hearthstone Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 E. Barnett Road Medford, OR 97504	

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>*A baseline audit of residents verified to have current wounds will be completed to ensure treatment orders are in place.</p> <p>*A baseline audit will be completed of residents with current wounds to ensure there is a wound evaluation in place.</p> <p>*A baseline audit will be completed to verify residents with current wounds have care plan for skin impairment risk in place and identify interventions to promote skin integrity and wound healing.</p> <p>*Licensed nurse staff will be provided education regarding completing thorough evaluation on admission to identify areas of skin impairment. Education would identify the need to initiate treatment orders for new admissions with identified skin impairments as well as any newly identified facility acquired skin impairments.</p> <p>*Unit managers will be educated regarding the admit review process to include review for identified areas of impaired skin integrity and to verify treatment orders were initiated, and care plans were initiated based on skin risk factors.</p> <p>*Unit Managers will be educated regarding the completion of weekly wound evaluations. The DON/Designee will ensure the wound evaluations are completed weekly for residents who are identified as having wounds.</p> <p>*Audits will be conducted by DON or designee weekly for four weeks then monthly for two months.</p> <p>*Audit trends will be reported to facility QAPI for three months for review and further recommendations.</p> <p>The IJ was removed on 5/28/24 at 3:58 PM, as confirmed by onsite verification by the survey team.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to ensure there was sufficient nursing staff available to provide the necessary care and services to meet residents' needs in 1 of 1 facility and for 4 of 4 sampled residents (#s 11, 22, 23 and 24) reviewed for staffing. This placed residents at risk for unmet care needs. Findings include:</p> <p>On 5/18/24 and 5/20/24 public complaints were received by the State Survey Agency which alleged the facility did not staff at a level to ensure resident care needs were met. Residents had fallen, attempted to elope and many residents were left in urine soaked bed sheets at night.</p> <p>The 4/2024 Resident Council Notes revealed slow call light response times and care staff not returning when residents requested items.</p> <p>The facility's 4/2024 and 5/2024 Direct Care Staff Daily Report revealed the facility was understaffed for CNAs for 7 of 20 days reviewed for the State minimum staffing requirement.</p> <p>On 5/23/24 at 3:50 PM, Resident 11 stated she/he had waited over an hour for her/his call light to be answered.</p> <p>On 5/28/24 at 12:01 PM, Resident 22 stated it often took a long time for call lights to be answered.</p> <p>On 5/28/24 at 3:17 PM, Resident 23 stated long call light wait times were frequent and were worse at the end of the week and on evening and night shifts. Resident 23 stated wait times were over one hour.</p> <p>On 5/28/24 at 3:18 PM, Resident 24 stated call light wait times took over one hour, wait times were worse later in the week and the weekend, and especially on evening and night shifts.</p> <p>On 5/22/24 at 6:05 PM, Staff 8 (LPN), Staff 19 (LPN), and Staff 31 (LPN) all stated the facility does not staff with enough CNA's to meet the needs of the residents; especially on Friday, Saturday and Sunday and on evening and night shifts. Staff stated it was difficult to get all the medications and treatments done and when they needed to pick up an extra wing they were not able to provide everything the residents needed. Staff further stated they were informed the facility would be cutting CMA's to one CMA on day shift and cuts to the licensed nurse staff.</p> <p>On 5/23/24 at 9:19 AM, Staff 7 (RN) stated there was not enough nursing staff to take care of the residents and medications were often administered late after she left her shift.</p> <p>On 5/23/24 at 9:30 AM, Staff 16 (LPN) stated she currently was assigned two wings but would also need to assist on the third wing later that day.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/23/24 at 9:36 AM, Staff 20 (LPN) stated she worked over twenty hours one day, the residents did not get the care they deserved and the nurses could not get all the medications and treatments done in their shift let alone if anything else came up that needed nursing assistance.</p> <p>On 5/28/24 at 2:20 PM, Staff 7 (RN) was observed to be frustrated, stated she was scheduled off shift at 2:00 PM and could not find coverage to leave the facility. The nurse that was supposed to pick up her residents was too busy with a recent resident fall and Staff 7 stated the Unit Manager refused to assume care of the residents.</p> <p>On 5/28/24 at 12:40 PM, Staff 2 (Regional Director of Clinical) acknowledged the low staffing levels.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>33179</p> <p>Based on interview and record review it was determined the facility failed to ensure the facility had nursing staff with the appropriate wound care competencies and skills sets for 12 of 12 licensed nurse staff reviewed for nursing services. This placed residents at risk for unmet wound care needs. Findings include:</p> <p>A review of the facility's employee list revealed 12 LPNs and RNs worked at the facility.</p> <p>On 5/22/23 and 5/23/23 a request was made to review documentation to ensure the facility and contract agency licensed nurse staff had the required wound care skills and competencies. No documented proof was provided.</p> <p>On 5/22/24 at 11:53 AM, Staff 19 stated she found Resident 6 had calcium alginate (wound dressing) over her/his surgical wound. This dressing was not ordered so she removed the dressing and reported it to Staff 3 and the physician.</p> <p>On 5/22/24 at 6:05 PM, Staff 8 (LPN), Staff 19 (LPN), and Staff 31 (LPN) all stated the facility did not complete skills competencies to ensure the new staff knew what they were doing before they provided wound and nursing care to the residents. Staff 8 and 31 further stated most nurses were not comfortable providing wound care, had received no wound care training from the facility and they did the best they could. Staff 19 and 31 stated one facility nurse regularly ignored physician wound care orders because she felt xeroform (a fine mesh gauze) was a better option so used that on all residents. Staff 19 stated she discovered calcium alginate (wound dressing) on Resident 7's surgical site. This dressing was not order. Staff 19 stated she removed the dressing and reported the treatment error to Staff 3 and Staff 4 (Unit Manager).</p> <p>On 5/23/24 at 9:36 AM, Staff 20 (LPN) verified staff did not get any wound care training and competencies were not checked by the facility prior to caring for the residents.</p> <p>On 5/28/24 at 12:40 PM, Staff 2 (Regional Director of Clinical) acknowledged the facility did not have any documentation showing staff competencies were checked.</p> <p>Refer to F684 and F686.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>35854</p> <p>Based on interview and record review it was determined the facility failed to ensure effective systems were in place to identify problems, and take action to improve and monitor its performance for 1 of 1 facility reviewed for quality assessment and assurance. This failure placed residents at risk for worsening care. Findings include:</p> <p>The facility's undated 2024 Quality Assurance and Performance Improvement (QAPI) Plan for Hearthstone Nursing and Rehabilitation Center included oversight of Administration, Clinical Care Services, Nutrition Services, Pharmacy Services, Quality of Life and Engagement, Maintenance Services, Housekeeping, and Training And Orientation. The plan included use of a QAPI Committee, Analytics, Core Processes, and Medical Oversight for purposes of Performance Improvement Projects, Systematic Analysis, Communication, QAPI Self-Assessment, as well as Feedback and Data Monitoring.</p> <p>A review of the facility's Quality Assessment and Assurance (QAA) records from 10/2023 through 5/28/24 revealed no evidence the facility enacted procedures related to problem identification, analysis, performance improvement, and monitoring.</p> <p>On 5/28/24 at 5:14 PM Staff 18 (Vice President of Operations) acknowledged the lack of evidence of an effective QAA program.</p>