

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 11/25/2025
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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to revise care plan interventions and re-evaluate a resident's elopement to ensure a resident's safety for 1 of 3 sampled residents (#1) reviewed for elopement. This placed residents at risk for repeated elopements. Findings include: Resident 1 admitted to the facility in 8/2025, with diagnosis including squamous cell cancer to the face, psychosis, delusional disorder and schizophrenia. Resident 1's profile page revealed Resident 1 had a guardian. On [DATE] Resident 1 was granted a guardian. The resident's guardianship paperwork included separate numbers for communication involving everyday contact through emergency contact. Resident 1's [DATE] admission MDS revealed she/he was independent with mobility; however she/he had impaired strength, balance and endurance that limited safe participation in daily routines. Resident 1's [DATE] Progress Note indicated she/he left the facility and a voice message was left for her/his guardian. Hospital Records dated [DATE] revealed Resident 1 was admitted to the hospital on [DATE] after being found wandering in the streets with a maggot infestation to her/his face and indicated Resident 1 had cognitive decline with suspected vascular dementia. The resident returned to the facility on [DATE]. Resident 1's [DATE] Care Plan indicated she/he was a low elopement risk and was at risk for falls related to impaired mobility due to vision impairment. Resident 1's care plan did not include the resident's elopement on [DATE], and no interventions were developed to ensure the resident's safety. Resident 1's [DATE] Progress Notes revealed she/he wanted to leave the facility. Both Staff 7 (Nurse) and Staff 3 (LPN, Assistant DON) attempted to educate the resident on her/his choice to leave the facility. Staff 3 observed Resident 1 leave the facility and get on a city bus. A voice message was left for Resident 1's guardian. A [DATE] Progress Note indicated Staff 3 was interviewed by a local law enforcement officer (LEO). Staff 3 informed the LEO the resident was alert and oriented, had the right to leave, the resident had signed the AMA form, education was given to the resident, and the guardian was notified. Resident 1's [DATE] Hospital Records indicated she/he was brought to the hospital after she/he left the facility two days prior. Bystanders were concerned for Resident 1 and had called 911. The records indicated the resident did not have decision making capability and it was inappropriate to allow Resident 1 to leave or sign out of the nursing facility. The facility did not complete an investigation for the [DATE] or [DATE] elopements. On [DATE] at 12:22 PM, Witness 1 (Guardian) verified Resident 1 eloped twice since her/his admission to the facility and stated both times she was not contacted on her emergency line, but instead, the facility left a voice message on her main telephone number. Witness 1 stated she had provided the facility with the guardianship papers with directions on how to contact her on two separate occasions and explained the resident did not have the capacity to make the decision to leave AMA (against medical advice). On [DATE] at 3:21 PM, Staff 8 (Former LPN) indicated she was not aware Resident 1 had a guardian. Staff 8 stated she worked alongside Staff 7 (RN), who was the AMA specialist when Resident 1 left AMA on [DATE]. Staff 8 stated she did not know why Resident 1 was allowed to leave the facility. On [DATE] at approximately 3:30 PM, Staff 3 (LPN, Assistant DON) verified on [DATE] she allowed Resident 1 to leave AMA and did not call the guardian's emergency number to notify the guardian of the situation but instead left a voice message on her main number. Staff 3 stated at the time of the [DATE] elopement, she believed Resident 1's previous guardianship papers had expired. On [DATE] at 3:49 PM, Staff 28 (CNA) stated Resident 1 was not safe to be in the community by herself/himself. On [DATE] at 3:53 PM, Staff 29 (LPN Unit Manager) stated Resident 1 left AMA on [DATE] and [DATE] and allowing the resident to leave AMA was a misunderstanding. On [DATE] at 4:00 PM, Staff 7 (RN) stated when Resident 1 left AMA on [DATE], there was no stopping her/him. Staff 7 stated he attempted to notify the guardian's primary number and not the emergency number because he was unaware there were additional contact numbers to reach the guardian. Staff 7 stated he did not call the police as he felt the resident was alert and oriented and was not aware the resident was not allowed to leave the facility. On [DATE] at 5:05 PM, Staff 1 (Administrator), Staff 2 (DON), and Staff 4 (Regional RN) verified Resident 1 left the facility on [DATE] and [DATE].</p>		