STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385091	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hearthstone Nursing & Rehabilitation Center	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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure residents were free from misappropriation of money for 1 of 4 sampled residents (#18) reviewed for abuse and misappropriation. This placed residents at risk for loss of property. Findings include:Resident 18 was admitted to the facility in 10/2025 with diagnoses including anxiety and depression. An admission MDS dated [DATE] indicated Resident 18 was cognitively intact. On 1/23/26, the State Survey agency received a public complaint which indicated on 1/19/26, Witnessˆ17 (Complainant) reviewed Residentˆ18's bank statement and found multiple charges on her/his card from 12/4/25 through 12/25/25. Residentˆ18 had not used her/his card and believed staff, or a visitor used the card. The total was $1,696.00 in charges. A police report was filed, but he had not reported it to the facility. A facility investigation completed on 2/20/26 indicated on 2/14/26 at approximately 5:00 PM officers from the police department arrived at the facility and showed a photograph of Staff 25 (CNA/Receptionist). The police reported bank card charges totaling approximately $1,700 in unknown purchases which started in 12/2025. The purchases were described as household goods and toys. Resident 18's bank card was in her/his billfold in her/his room. Staff 25 reported to the facility she used $100 for her personal use, and her intent was to pay the resident back. Misappropriation of funds was identified with Staff 25 acknowledging use of the bank card. On 2/24/26 at 9:10 AM, Witness 17 stated there was pictures of the Staff 25 making purchases in the store. On 2/25/26 at 11:17 AM, Resident 18 stated she did not authorize the purchases. Resident 18 stated she currently felt safe in the facility and the police saw pictures of the person who took her/his money. On 3/3/26 at 10:05 AM, Staff 25 stated Resident 18 kept requesting snacks and kept crying and begging for someone to get them for her/him. Staff 25 stated she regretted using Resident 18's card and stated Resident 18 was like family and borrowing money from family. On 3/4/26 at 12:07 PM, Staff 1 (Administrator) and Staff 2 (DNS) stated they would expect staff not to use a resident's bank card. The deficient practice was identified as Past Noncompliance based on the following: On 2/16/26, the deficient practice was identified by the facility and was corrected when the facility completed an investigation and identified system failures in the identification of misappropriation. The Plan of Correction included: -Staff 25 was terminated and reported to OSBN. -Resident 18 would be monitored for negative psychosocial impact. -Baseline interview audit of residents and/or resident family members to ensure there are no additional resident who have experienced misappropriation of funds by a staff member. -Education to current active staff regarding misappropriation. -Monitoring conducted weekly for four weeks, then monthly for two months. -Audit trends to be reported to the facility QAPI for three months for review and further recommendations. -Resident council meeting was conducted to review resident rights to have personal belongings maintained safely within the facility and options for storage.

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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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. Based on interview and record review it was determined the facility failed to ensure residents received required admissions documents at or before admission for 1 of 3 sampled residents (#9) reviewed for resident rights. This placed residents at risk for not understanding their rights and services. Findings include:Resident^9 was admitted to the facility in 10/2025 with diagnoses including diverticulosis (small pouches in the colon) and cognitive communication deficit (trouble understanding or expressing speech). A certified mail receipt dated 2/6/26 with a handwritten note revealed the admissions packet was generated on 10/30/25 and discovered it was not signed. The packed was sent via certified mail to Resident 9. On 2/23/26 at 2:02 PM, Witness 19 (Family Member) confirmed Resident 9 did not receive her/his admission documents until after she discharged from the facility, and she/he received by certified mail. On 3/4/26 at 10:37 AM, Staff 27 (Admissions Director) stated he noticed some residents did not receive their admissions documents upon admission to the facility. Staff 27 sent them in the mail to the residents who had not received. Staff 27 stated a lot of staff had been in the position and some were terminated and some quit. On 3/4/26 at 11:58 AM, Staff 2 (DNS) stated she expected staff to provide residents their admission documents timely.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, it was determined the facility failed to ensure dependent residents received required assistance with ADLs for 3 of 5 sampled residents (#s 3, 6, and 13) reviewed for ADLs and call lights. This placed resident at risk for unmet needs. Findings include:1. Resident 3 was admitted to the facility in 6/2025 with diagnoses including muscle weakness and adult failure to thrive. A 6/30/25 admission MDS indicated Resident 3 had moderate cognitive impairment and was dependent on staff for showers. The 8/2025 Documentation Survey Report (CNA task report) indicated Resident 3 did not receive any type of bathing from 8/10/25 through 8/19/25 (10 days). On 8/13/25 and 8/16/25 the documentation indicated NA. On 3/3/26 at 9:07 AM, Staff 17 (CNA) stated she would document NA when she did not have time to provide a shower for a resident in 8/2025. On 3/3/26 at 9:40 AM, Staff 18 (CNA) stated there were times in 8/2025 showers were not offered to residents.On 3/4/26 at 11:51 AM, Staff 2 (DNS) stated she would expect residents to receive their scheduled showers. 2. Resident 6 was admitted to the facility in 12/2024 with diagnoses including chronic kidney disease and urinary tract infection. A 7/3/25 Quarterly MDS indicated Resident 6 was cognitively intact and was dependent on staff for toileting transfer and hygiene. Resident 6 was occasionally incontinent of bladder. On 2/27/25 at 8:00 AM, Resident 6 stated at times she/he had to wait up to an hour to have staff assist with toileting. Resident 6 stated when she/he had to wait a long time she/he would hurt and had to urinate really bad. Resident 6 stated the daytime was the worst for long waits. On 3/3/26 at 9:58 AM, Staff 25 (Former CNA) stated she has observed Resident 6 have an incontinent episode from having to wait a long time. On 3/3/26 at 2:30 PM, Staff 29 (CNA) stated she had seen Resident 6's call light on, and the resident would tell her she/he was waiting to use the toilet. Staff 29 stated she would apologize when she could not met residents' care needs. On 3/4/26 at 10:21 AM, Staff 41 (CNA) stated she had observed Resident 6 have an incontinent episode from having to wait too long for assistance with toileting. On 3/4/26 at 11:53 AM, Staff 2 (DNS) stated she would expect staff to assist so Resident 6 would not have incontinent episodes. 3. Resident 13 was admitted to the facility in 6/2025 with diagnoses including muscle weakness and a need for assistance with personal care. A 6/30/25 admission MDS indicated Resident 13 required partial to moderate assistance of one staff with bathing. A 7/10/25 Care Plan documented Resident 13 required substantial to maximal assistance of one staff with bathing. The 11/2025 Documentation Survey Report revealed Resident 13 was scheduled for bathing on Tuesday and Saturday evenings. The report indicated Resident 13 received bathing four times in 11/2025, and no bathing from 11/12/25 through 11/21/25 (10 days). On 12/11/25 the State Survey agency received a complaint indicating Resident 13 was not receiving bathing. On 3/3/26 at 3:01 PM, Staff 58 (Agency CNA) stated she did not remember Resident 13 refusing bathing in 11/2025 and stated at times could not complete resident's bathing. On 3/4/26 at 11:51 AM, Staff 2 (DNS) stated she would expect residents to receive their scheduled showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review it was determined the facility failed to follow physician orders for 1 of 4 sampled residents (#19) reviewed for medications. This placed residents at risk for delayed treatment and unmet medication needs. Findings include:Resident 19 was admitted to the facility in 12/2025 with diagnoses including chronic pain and sepsis.A 12/2025 MAR instructed staff to administer the following medications on 12/31/25:-Linezolid (an antibiotic medication) for sepsis; referred the reader to Administration Notes-Oxcarbazepine (an anticonvulsant medication) for convulsions; referred the reader to Administration Notes -Gabapentin (an anticonvulsant medication) for pain; referred the reader to administration notes.Administration Notes dated 12/31/25 revealed the following medications were on order from the pharmacy:-Linezolid for sepsis-Oxcarbazepine for convulsions-Gabapentin for painOn 2/4/26 the State Survey agency received a complaint indicating Resident 19 missed physician-ordered medications. On 3/3/26 at 12:38 PM, Staff 22 (CMA) stated Resident 19 was sent to the hospital and when she/he returned someone had destroyed all her/his medications. Staff 22 stated the resident was not gone long and the situation was frustrating due to the resident did not receive her/his medications. On 3/4/26 at 12:05 PM, Staff 2 (DNS) stated she would expect staff to communicate with pharmacy and have no lapse in resident medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review it was determined the facility failed to ensure resident records were complete and accurate for 3 of 14 sampled residents (#s 1, 4, and 12) reviewed for medical records. This placed residents at risk for inaccurate medical records. Findings include:1. Resident 1 was admitted to the facility in 1/2025 with diagnoses including diabetes. Resident 1's 12/2025 DAR (Diabetic Administration Record) indicated for staff to administer insulin before meals. The 5:30 PM administration time, had 4 out of 31 instances where no documentation to indicate if Resident 1 refused or was administered their insulin. The 5:00 PM administration time had 4 out of 31 instances with no documentation on the DAR and the 8:00 PM administration had 1 of 31 instances where no documentation was indicated for insulin administration. On 3/4/26 at 10:06 AM, Staff 28 (LPN) stated Resident 1 would refuse and ask for insulin later, and when offered later, she/he would refuse again. Staff 28 stated she forgot to document the resident's refusal on the DAR. On 3/4/26 at 11:46 AM, Staff 2 (DNS) stated the expectation of staff was to document residents' refusals on the DAR. 2. Resident 4 was admitted to the facility in 1/2025 with diagnoses including traumatic brain injury and dementia. A 6/10/25 Quarterly MDS indicated Resident 4 was rarely understood and dependent on staff for eating. A care plan revised on 12/12/24 revealed Resident 4 was totally dependent on one staff for eating. A Documentation Survey Report for 8/2025 revealed out of 124 opportunities, staff documented Resident 4 as independent with eating on ten occasions and requiring setup or clean-up assistance on four occasions. On 3/3/26 at 9:52 AM, Staff 25 (CNA) stated she should not have documented Resident 4's eating assistance as independent, since she/he always had been dependent and required staff support with eating. On 3/4/26 at 11:52 AM, Staff 2 (DNS) stated she expected staff to provide accurate documentation of residents' eating assistance requirements. 3. Resident 12 was admitted to the facility in 10/2025 with diagnoses including muscle weakness, lack of coordination, and Alzheimer's disease. A 10/7/25 admission MDS indicated Resident 12 had significant cognitive issues and required substantial to maximal assistance from staff for dressing. A care plan dated 10/15/25 revealed Resident 12 required substantial to maximal assistance of one staff for lower-body dressing. A Documentation Survey Report for 11/2025 revealed out of 61 opportunities, staff documented Resident 12 as independent with lower body dressing on three occasions. On 3/3/26 at 9:45 AM, Staff 18 (CNA) stated the charting use to be weird and unclear on what to document. Staff 18 stated she probably missed documenting Resident 12's lower body dressing abilities. On 3/4/26 at 11:52 AM, Staff 2 (DNS) stated she expected staff to provide accurate documentation of residents' dressing abilities.