

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 05/23/2025
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>40774</p> <p>Based on interview and record review, it was determined the facility failed to protect the resident's right to be free from abuse for 2 of 2 sampled residents (#s 32 & 208) reviewed for abuse. This placed residents at risk for mental anguish and abuse. Findings include:</p> <p>Review of the facility's 3/2025 Freedom from Abuse, Neglect and Exploitation Policy and Procedures revealed:</p> <p>Definition of willful: The individual must have acted deliberately (not an inadvertent or accidental action), not that the individual must have intended to inflict injury or harm.</p> <p>1. Resident 32 admitted to the facility in 2022 with diagnoses including stroke affecting dominant side and mood disorder.</p> <p>Resident 32's 3/15/25 Quarterly MDS indicated the resident was severely cogitatively impaired.</p> <p>2. Resident 208 readmitted to the facility in 3/2025 with diagnoses including dementia and agitation.</p> <p>Resident 208's 3/15/25 Admission MDS indicated the resident was cognitively intact.</p> <p>On 4/3/25 at 8:30 PM, an Alleged Abuse incident report completed by Staff 1 (Administrator) revealed Staff 11 (RN) reported Staff 12 (CNA) and Staff 18 (CNA) witnessed Resident 208 touching Resident 32's breast at approximately 5:45 PM, in the dining room.</p> <p>On 4/3/25 Staff 12's (CNA) witness statement indicated around dinnertime, she observed Resident 208 attempting to touch Resident 32's chest. Staff 12 reported the incident to Staff 16 (RN) and was instructed to move Resident 208 away from Resident 32. Staff 12 informed Resident 208 that she/he needed to sit in a different location at which point Resident 208 became angry and attempted to approach Resident 32 again.</p> <p>(continued on next page)</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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/3/25 Staff 16's (RN) witness statement indicated he was notified by a CNA about difficulty keeping Resident 208 out of the dining room and away from Resident 32. Staff reported Resident 208 had been re-directed and removed from the area several times but continued to return. Staff 16 instructed the CNAs to keep Resident 208 away from Resident 32, to continue to monitor both residents, and to notify him if Resident 208 attempted to approach Resident 32 again.</p> <p>On 4/3/25 Staff 17's (CNA) witness statement indicated she was trying to help move Resident 208 away from Resident 32. Resident 208 was saying do you want some of this? while pointing downward and looking towards Resident 32. Staff 17 stated Resident 208 was resistive at first then stopped trying to approach Resident 32.</p> <p>On 4/3/25 Staff 18's (CNA) witness statement indicated he witnessed Resident 208 touching Resident 32's breast in the dining room and Staff 12 moved Resident 208 away from Resident 32.</p> <p>On 4/11/2025 at 12:55 PM, a social services note indicated staff were called to Resident 208's room in response to reports of unruly behavior and verbal threats directed toward staff and other residents. The facility contacted the local police department and emergency medical transport (EMT) to facilitate a psychiatric evaluation at an emergency department. During the EMT's attempt to transport the resident, Resident 208 reportedly stated, If I get you alone, I'll knock your fucking teeth out. The resident's family was notified of the incident and informed that, due to the nature of the behavior, Resident 208 would not be readmitted to the facility following the evaluation.</p> <p>On 4/11/2025 at 3:09 PM, a social services note documented that Resident 208 underwent a psychiatric evaluation and was subsequently returned to the facility.</p> <p>On 4/17/2025 at 4:59 PM, an alert note documented Resident 208 was verbally aggressive toward staff and another resident. While staff were assisting another resident in the hallway, Resident 208 reportedly stated an aggressive remark. The other resident turned around in response to the verbal outburst, at which point Resident 208 directed the comment, Fuck you big guy, what are you going to do about it? toward the resident. Staff intervened however, removal of Resident 208 from the area was challenging due to continued aggression.</p> <p>On 5/21/25 at 2:31 PM, Staff 18 (CNA) confirmed he witnessed Resident 208 touch Resident 32's breast in the dining room. Staff 18 separated both residents and asked Staff 12 to tell the charge nurse while he kept the residents apart.</p> <p>On 5/22/25 at 1:51 PM, Staff 12 (CNA) stated when she brought another resident into the dining room for dinner she saw Resident 208 touch Resident 32's breast. Staff 12 stated when she tried to separate Resident 208 she/he tried to follow Resident 32 and became verbally aggressive.</p> <p>On 5/22/25 at 8:45 PM, Staff 11 (RN) stated on 4/3/25 at approximately 8:15 PM, Staff 12 and Staff 18 reported earlier that day they both witnessed Resident 208 touch Resident 32's breast in the dining room during dinner time. Staff 11 stated immediate safety interventions were put into place, residents' family and appropriate staff were notified.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/23/25 at 11:48 AM, Staff 1 (Administrator) acknowledged the sexual contact between Resident 32 and Resident 208. Staff 1 stated neither resident had the mental capacity to consent. Staff 1 stated he did not believe the resident's actions were willful and did not believe the facility could have prevented the resident's behavior or rule out abuse or neglect. Staff 1 acknowledged the facility had an obligation to ensure residents were free from abuse.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>40774</p> <p>Based on interview and record review it was determined the facility failed to ensure alleged violations involving sexual abuse were reported immediately, but no later than two hours after the allegation is made for 2 of 2 sampled residents (#s 32 and 208) reviewed for abuse. This placed residents at risk for abuse. Findings include:</p> <ol style="list-style-type: none"> 1. Resident 32 admitted to the facility in 2022 with a diagnoses including stroke affecting dominant side and mood disorder. <p>Resident 32's 3/15/15 Quarterly MDS indicated the resident was (severely cognitively impaired).</p> <ol style="list-style-type: none"> 2. Resident 208 readmitted to the facility in 2025 with diagnoses including dementia and agitation. <p>Resident 208's 3/15/25 Admission MDS indicated she/he was (cognitively intact).</p> <p>Review of the incident investigation dated 4/3/25 indicated at approximately 5:45 PM, Staff 12 (CNA) and Staff 13 (CNA) witnessed Resident 208 touch Resident 32's breast in the dining. At approximately 8:15 PM, Staff 12 and Staff 13 notified Staff 11 (RN).</p> <p>A FRI was received on 4/3/25 at 9:23 PM, the report indicated staff witnessed Resident 208 touched Resident 32's breast at 5:45 PM.</p> <p>On 5/22/25 at 8:45 PM, Staff 11 (RN) stated on 4/3/25 at approximately 8:15 PM, Staff 12 and Staff 13 reported at approximately 5:30 PM, they both witnessed Resident 208 touch Resident 32's breast in the dining. Staff 11 stated she notified Staff 1 (Administrator) but did not submit the FRI.</p> <p>On 5/23/25 at 11:48 AM, Staff 1 (Administrator) acknowledged the facility failed to report alleged allegations of sexual abuse timely to the State Agency.</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>34703</p> <p>Based on interview and record review it was determined the facility failed to develop a comprehensive assessment for 1 of 3 residents (#31) reviewed for tube feeding. This placed residents at risk for unmet nutritional needs and weight loss.</p> <p>Resident 31 was admitted to the facility in 4/2025 with diagnoses including a feeding tube.</p> <p>The 5/3/25 Admission Nutritional Status CAA indicated Resident 31 had nutritional problems or potential problem related to acute kidney failure, UTI, diabetes, severe septic shock, high blood pressure and Enteral feeding. (tube feeding.) The Admission Nutritional CAA did not include Resident 31's eating pattern, communication problems, resident or family input, or care plan considerations.</p> <p>On 5/22/25 at 11:57 AM Staff 22 (MDS Coordinator) acknowledged the 5/22/25 Admission MDS Nutritional CAA did not include Resident 31's current eating pattern, communication problems, resident or family input, or care plan considerations. Staff 22 acknowledged the 5/22/25 Admission MDS Nutritional CAA needed more information and was not comprehensive.</p> <p>On 5/22/25 at 1:56 PM Staff 2 (DNS) acknowledged the 5/22/25 Admission MDS Nutritional CAA did not include Resident 31's current eating pattern, communication problems, resident or family input, or care plan considerations. Staff 2 acknowledged the 5/22/25 Admission MDS Nutritional CAA was not comprehensive and her expectation was for staff to make the CAA person centered for Resident 31.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>41455</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure dialysis (a procedure which removes waste products and excess fluid from the blood when the kidneys are no longer functioning properly) services were completed, including monitoring and communication with the dialysis provider for 1 of 1 sampled resident (#44) reviewed for dialysis. This placed residents at risk for delayed treatment and medical complications related to dialysis. Findings include:</p> <p>Resident 44 was admitted to the facility in 3/2025 with diagnoses including heart failure and end stage renal disease.</p> <p>The 3/11/25 Admission MDS indicated Resident 44 had a BIMS score of 12 (moderate cognitive impairment), received a therapeutic diet, and was at risk for fluid overload due to end stage renal disease.</p> <p>a. A 3/10/25 physician order indicated nursing staff were to complete the post-dialysis form after Resident 44 returned from dialysis. Staff were to ensure the resident returned with the Pre-Dialysis Assessment and Communication Form completed and follow up as indicated with dialysis if the form was not returned with the resident every Monday, Wednesday, and Friday.</p> <p>A 4/8/25 revised care plan revealed Resident 44 received dialysis on Mondays, Wednesdays, and Fridays.</p> <p>A review of the 5/2025 Pre/Post Dialysis Assessment forms revealed on 5/12/25, 5/14/25, and 5/21/25 dialysis forms were either incomplete or contained inaccurate weights for the day of dialysis.</p> <p>On 5/22/25 at 8:38 AM, Resident 44 stated she/he took forms with her/him to dialysis and dialysis was to FAX the information back to the facility.</p> <p>On 5/22/25 at 8:42 AM, Staff 10 (LPN) stated he worked both night and day shifts. Staff 10 indicated the night nurse was responsible to ensure the post-dialysis information was received from dialysis by FAX and the dialysis assessment form was completed. Staff 10 stated the expectation was to obtain accurate weights and vitals on the day of dialysis from facility staff for pre-dialysis data.</p> <p>On 5/22/25 at 9:38 AM, Staff 6 (Unit Manger) stated it was difficult to get the dialysis forms returned from dialysis. Staff 6 stated nursing staff was expected to follow up with dialysis in order to accurately assess and monitor Resident 44. Staff 6 stated correct data on Resident 44 was needed for all dialysis assessments and the expectation for dialysis care for Resident 44 was not met.</p> <p>On 5/23/25 at 1:07 PM, Staff 2 (DNS) stated she expected staff to contact dialysis if the dialysis information was not received. Staff 2 acknowledged timely and complete dialysis assessments for Resident 44 were necessary.</p> <p>b. The 2021 facility's Diet and Nutrition Care Manual indicated a Liberalized Renal Diet for dairy products may be limited if phosphorous (a mineral) was a concern.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 3/10/25 Diet Profile indicated Resident 44 was to receive a renal diet (foods lower in sodium, potassium, and phosphorus), large portions, and disliked meat and eggs.</p> <p>A 5/5/25 Nutrition Communication from dialysis indicated Resident 44's phosphorus levels were elevated and a high-protein, mostly vegan diet was recommended with a note which indicated Resident 44 will consume small amounts of cottage cheese. Recommendations included a double portion of protein to include tofu and beans due to the resident's hunger. An acknowledgement note handwritten by Staff 3 (Assistant Director of Nursing) on the Nutrition Communication form indicated Resident 44 already received large portions and extra protein.</p> <p>A 5/19/25 Nursing Progress Note indicated Resident 44 returned from dialysis with a note which indicated the resident had excessive weight gain; the dialysis center was unable to remove all fluid and requested Resident 44 be placed on a low sodium diet.</p> <p>On 5/21/25, an undated Sack Lunches for Renal Diets list was observed on the snack refrigerator door located near the the dining room. The posted list included a list of items not appropriate for renal diets. Cottage cheese (a food high in sodium and phosphorus) was not on the list.</p> <p>On 5/20/25 at 5:00 PM, Resident 44 stated staff, from the dialysis center, indicated her/his diet needed more protein. Resident 44 stated she/he received few protein options with her/his meals. Review of Resident 44's 5/20/25 breakfast meal ticket revealed no protein was provided.</p> <p>On 5/21/25 at 8:55 AM, Staff 5 (Dietary Manager) stated there was a notebook in the dining room which included a list of all resident diets with diet education. Staff 5 indicated the notebook was available for everyone, including nursing staff.</p> <p>On 5/21/25 at 1:20 PM and 1:24 PM, Staff 8 (CNA) and Staff 9 (CNA) stated Resident 44 was often hungry and cottage cheese was routinely provided to Resident 44 as a snack because she/he did not like meat or eggs. Staff 9 and Staff 8 were unaware to limit cottage cheese for Resident 44 and had no knowledge of the resident diet list or notebook.</p> <p>On 5/22/25 at 11:13 AM, Staff 3 stated weekly meetings occurred with Staff 7 (RD) and Resident 44's diet was not updated timely. Staff 3 stated a faster process was needed to ensure diets were updated.</p> <p>On 5/22/25 at 12:02 PM, Staff 5 stated the communication of diet orders for Resident 44 was confusing. Staff 5 acknowledged improved renal diet information and diet training for nursing staff was needed.</p> <p>On 5/22/25 at 12:30 PM, Staff 7 acknowledged she was aware of the 5/5/25 dietary communication related to Resident 44's dietary needs, which was not yet fully addressed. Staff 7 stated some cottage cheese for Resident 44 was acceptable and more direct communication between dialysis staff and Staff 7 was expected to timely address the nutritional needs of Resident 44.</p> <p>On 5/23/25 at 1:07 PM, Staff 2 (DNS) acknowledged improved dietary information, direction, and training were necessary related to Resident 44 and renal diets.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>41455</p> <p>Based on interview and record review it was determined the facility failed to follow up on dental services for 1 of 1 sampled resident (#6) reviewed for dental services. This placed residents at risk for unmet dental health needs. Findings include:</p> <p>A 3/2023 facility Dental Service policy indicated the facility was to assist the resident in making dental appointments if necessary or requested.</p> <p>Resident 6 was admitted to the facility in 5/2021 with diagnoses including bipolar disorder (mental health condition characterized by extreme moods) and chronic pain.</p> <p>A 12/5/24 IDT (Interdisciplinary Team) Care plan Conference/Welcome Meeting Form indicated Resident 6 requested follow-up appointments for dental work that began during the prior months.</p> <p>A 3/4/25 Quarterly MDS indicated Resident 6 had a BIMS score of 14 (cognitively intact) and had obvious or probably cavities or broken teeth.</p> <p>A 3/11/25 IDT Care Plan Conference/Welcome Meeting Form indicated Resident 6 required dental services, including routine cleaning.</p> <p>A 3/13/25 revised care plan indicated Resident 6 required one staff to set up or assist with oral care.</p> <p>On 5/19/25 at 1:54 PM, Resident 6 stated she/he requested dental work because of five areas in her/his mouth that needed attention. Resident 6 reported she/he continued to request assistance with dental appointments during care conferences, but no appointments occurred.</p> <p>On 5/20/25 at 4:17 PM, Staff 20 (CNA) stated Resident 6 had no dental pain. Staff 20 stated Resident 6 often remained in bed, the resident was able to perform her/his own dental care, and declined offers to set up her/his tooth brush and toothpaste when tired.</p> <p>On 5/21/25 at 10:51 AM, Staff 4 (Social Service Director) recalled Resident 6's requests for dental services during the 12/2025 and 3/2025 care conferences. Staff 4 stated Staff 14 (Receptionist) was responsible to schedule dental appointments for residents and was expected to update Staff 4 regarding Resident 6's dental appointment needs. Staff 4 stated she expected updates within two weeks of Resident 6's dental appointments and acknowledged the follow up was missed.</p> <p>On 5/21/25 at 12:02 PM, Staff 14 stated she was aware Resident 6 had a dental appointment on 1/22/25 and was to receive provider notes upon Resident 6's return. Staff 14 stated she did not contact the provider for notes when Resident 6 returned without documentation.</p> <p>On 5/23/25 at 1:00 PM, Staff 2 (DNS) stated the transportation company that transported Resident 6 to the 1/22/25 dental appointment reported Resident 6 had a fractured tooth. Staff 2 expected staff to follow-up on all resident appointments.</p>		