STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385064	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care of Rogue Valley	1710 NE Fairview Avenue Grants Pass, OR 97526

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to provide required communication and documentation for 2 of 3 sampled residents (#s 49 and 51) reviewed for hospitalization and discharge. This placed residents at risk for unsafe discharge. Findings include: The 8/2024 Facilities Bed Hold Policy and Agreement Form indicated a resident who was temporarily absent from the facility because of a Break in Services (defined under Oregon law as a hospitalization or leave of absence) may apply for a bed hold to ensure her/his bed was preserved for her/his anticipated return. The policy indicated at the time of discharge to the hospital; the discharging nurse would give the residents and representatives a copy of the Bed Hold Policy and Agreement.1.Resident 51 was admitted to the facility on [DATE] with diagnoses including muscle weakness and stroke.On 1/18/26, Resident 51 left for a physician appointment. After the appointment, Resident 51 went home with Witness 1 (Family Member). On 1/18/26 at 10:37 PM, Staff 5 (RN) spoke with Witness 1 on the phone. Witness 1 indicated Resident 51 fell asleep and would not return to the facility that night but would return the following day.On 3/24/26 at 1:33 PM, Witness 1 stated Resident 51 returned to the facility the following day, but when she/he arrived, the facility had discharged the resident. Witness 1 stated there was no notification the resident would be discharged and the resident was not offered a bed hold. On 3/25/26 at 12:17 PM, Staff 3 (Social Services) stated she oversaw discharges but if a resident went home for an overnight visit, the RCM or DNS oversaw the leave. Staff 3 stated when a resident went out overnight her/his bed was held and they were not charged.On 3/25/26 at 12:53 PM, Staff 6 (RNCM) stated Resident 51 returned to the facility after 24 hours and management decided she/he would be discharged . Staff 6 stated the overnight visit was a therapeutic leave and Resident 51's bed should have been held for his/her return. Staff 6 acknowledged staff did not call the spouse in the morning to discuss what time the resident would return, no documentation was sent to the resident or spouse regarding discharge or bed hold, and Resident 51 should not have been discharged .On 3/25/26 at 1:54 PM, Staff 3 stated Resident 51 went to her/his appointment and did not return by midnight and the IDT considered her/him leaving the facility AMA (against medical advice). Staff 3 stated Resident 51 and Witness 1 should have been called regarding return to the facility and they were not. Staff 3 acknowledged no discharge documentation or bed hold information was sent to Resident 51 or Witness 1.On 3/26/26 at 10:28 AM, Staff 1 (Administrator) acknowledged Resident 51 did not receive documentation regarding a discharge, was not offered a bed hold, and was not assessed for a safe discharge. Staff 1 stated Resident 51's discharge was unplanned and unsafe.2. Resident 49 was admitted to the facility in 12/2025 with diagnoses including respiratory failure and kidney disease.A progress note dated 1/4/26 indicated Resident 49 had oxygen saturation of 52% on room air, secretions in her/his lungs which could not be cleared with suctioning (removal of airway secretions), and respirations were labored. Staff 3 (LPN) provided oxygen, contacted the family who agreed to send the resident to the hospital, and called emergency transport.On 3/25/26 at 12:15 PM, Witness 3 (POA) stated when Resident 49 was sent to the hospital she/he was not offered a bed hold for her/his return.On 3/25/26 at 12:17 PM, Staff 3 (Social Services) stated she oversaw discharges (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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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and provided bed holds for residents or their POAs. Staff 3 stated she did not provide a bed hold for Resident 49 or her/his POA.On 3/26/26 at 10:46 AM, Staff 1 (Administrator) acknowledged residents or their POAs needed to be offered a bed hold when they were discharged to the hospital or on leave of absence from the facility.