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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 385148 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Royale Gardens Health & Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2075 NW Highland 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) |
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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>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38139</p> <p>Based on interview and record review it was determined the facility failed to assess the effectiveness of interventions and provide adequate resident supervision to prevent falls for 1 of 3 sampled residents (#s 102) reviewed for accidents. This placed residents at risk for recurring falls. Findings include:</p> <p>Resident 102 was admitted to the facility in 2024 with diagnoses including dementia, and repeated falls.</p> <p>Resident 102 had a BIMS score of 5 which indicated severe cognitive impairment. The resident had a total of 27 falls during the two months she/he was at the facility.</p> <p>Resident 102's care plan dated 9/30/2024 indicated the resident was a two person extensive assist with bathing/showering, transferring, and locomotion.</p> <p>Resident 102's 10/7/24 Fall Risk Care Plan instructed staff to anticipate and meet the resident's needs, keep the call light within reach, encourage use of the call light, educate the resident about safety reminders, ensure commonly used items were within reach, wear appropriate footwear, keep the bed in a low position, and a PT consult for strength and mobility.</p> <p>A review of the facility's fall Incident Reports revealed Resident 102 had 27 falls while at the facility from 10/3/24 through 12/1/24. There were 7 falls with staff assist to the ground or while staff were assisting the resident, 8 falls were witnessed, and 12 falls were unwitnessed.</p> <p>A review of the 27 Fall Incident Reports for Resident 102 from 10/3/24 through 12/1/24 revealed:</p> <p>-For 21 of the incident reports indicated Resident 102's care plan interventions at the time of the fall were frequent rounding, call light within reach, and staff-provided care.</p> <p>-The 10/4/24 a report included a gait belt was in place at the time of the intervention. The resident was ambulating alone in the hall.</p> <p>-The 11/14/24, 11/26/24, and 11/27/24 reports did not contain what interventions were in place at the time of falls.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>-The 11/28/24 report indicated Resident 102 was using the proper wheelchair at the time of the fall, which as not listed as a fll intervention on the resident's care plan.</p> <p>-The 10/13/24 and 11/6/24 the report indicated an intervention as the resident's walker was nearby which was not listed as an intervention on the resident's care plan,</p> <p>-The 10/13/24 and 10/14/24 incident reports also included an intervention to use visual reminders to ask for assistance which was not listed as an intervention on the resident's care plan.</p> <p>There was no documented evidence the facility conducted an analysis of the resident's falls to evaluate if her/his fall interventions were effective or appropriate.</p> <p>On 1/14/25 at 3:38 PM, Witness 2 (family member) stated the resident was at high risk for falls and required two-person assistance for transfers and showers. The resident had many falls while at the facility. On 12/1/24 the facility staff called the family and told them the resident fell in the shower and was sent to the hospital. The resident was diagnosed with damage from previous falls and a new brain bleed.</p> <p>On 1/16/24 at 8:55 AM, Witness 4 (LCSW/Veteran's Administration) stated Resident 103 had multiple falls while at the facility. Witness 4 further stated she has met with the Ombudsman and facility staff because the resident was having frequent falls and felt the facility did not have good fall interventions in place as the resident continued to fall.</p> <p>On 1/21/24 at 2:02 PM, Staff 5 (CNA) stated she was the CNA who assisted Resident 102 in the shower on 12/1/24 and had heard the resident had two falls earlier in the morning. Staff 5 stated Resident 102 needed one to one care because of the frequent falls but the facility did not have the staff to provide that level of care.</p> <p>On 1/21/25 at 2:23 PM, Staff 6 (CNA) stated Staff 5 completed a shower with the resident and she called for help because the resident became unresponsive. Staff 6 further stated the facility was often under staffed and when they were not staffed adequately they were unable to monitor residents who high fall risks.</p> <p>On 1/15/25 at 9:12 AM, Staff 12 (Nurse) stated Resident 102 was sent to the hospital often for falls. Staff 12 stated she had warned staff and the resident's family that the fall interventions in place were not adequate and did not work. Staff 12 further stated there was not enough staff to monitor Resident 102 who had sundowning behaviors and was impulsive. Staff 12 stated the resident needed one-to-one caregiver during waking hours.</p> <p>On 1/22/25 at 4:14 PM, Staff 1 (Administrator) stated they felt Resident 102's care plan was followed for both falls on 12/1/24. Staff 1 did not address how the care plan was followed for the resident's unwitnessed fall. Staff 1 was unable to address why Resident 102 had 27 falls in two months or why there was no assessment of the effectiveness or appropriateness of Resident 102's fall interventions.</p> | | |