

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 02/28/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38139</p> <p>Based on interviews and record review, it was determined the facility failed to treat, assess, and monitor wounds for 3 of 3 sampled residents (#s 101, 102, and 103) reviewed for wound care. This placed residents at risk for worsening wounds and infections. Findings include:</p> <p>1. Resident 101 admitted to the facility on ,d+[DATE], with diagnoses including mononeuropathy of the bilateral lower limbs (damage or dysfunction of two or more peripheral nerves in both legs), second degree burns of the right foot (2nd and 3rd toes) and second degree burns to the left foot and toes.</p> <p>Resident 101's 2/13/25 Hospital Discharge Orders indicated to continue local dressing changes daily with Xeroform and a dry sterile dressing.</p> <p>Resident 101's 2/13/25 Nursing Admission/Readmission Evaluation included the following skin observation:</p> <p>-Right toe(s): burns, blisters</p> <p>-Left toe(s): burns, blisters</p> <p>No additional information related to the wounds was found such as: description, measurements, which toes were involved, or the condition of surrounding tissues. The skin evaluation did not contain any information related to the burn wound on the upper aspect of the left foot.</p> <p>Resident 101's 2/15/25 Nursing Admission Skin & Wound Evaluation indicated she/he had a second degree burn on the right dorsum, 2nd digit (toe) with no evidence of infection. There was no Skin & Wound Evaluation found for the left foot.</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
---	-------	-----------

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 02/28/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/24/25 at 4:24 PM, Witness 1 (Hospital Social Worker) reported Resident 101 sustained burns to both feet from a space heater at home. The resident discharged from the hospital to the nursing home on 2/13/25 with orders to change the Xeroform and sterile dressings (inner and outer dressings) daily. Witness 1 stated that on 2/20/25, the facility wound nurse observed that the resident had smelly discharge, discoloration to the left great toe, as well as pain and swelling. Resident 101 was readmitted to the hospital on 2/20/25, and reported to the hospital podiatrist that the nursing facility staff had not changed the Xeroform dressing on her/his wounds for four of the seven days she/he was at the facility. On 2/24/25, while at the hospital, Resident 101 had debridement performed on both feet and the removal of second and third toenail beds of the right foot.</p> <p>Resident 101's 2/2025 TAR indicated the resident's wound orders of 2/13/25 was not initiated until 2/15/25, two days after the resident's admission to the facility.</p> <p>A review of Resident 101's TAR for 2/2025 revealed the order for the wound care was not transcribed onto the TAR until 2/15/25 or two days after admission.</p> <p>On 2/28/25 at 9:58 AM, Staff 4 (Wound Nurse/RN) stated nursing staff did not transcribe Resident 101's wound orders, there was no documentation showing that nursing staff implemented the resident's wound care during the first two days of admission, and staff</p> <p>did not monitor the resident's wounds. Staff stated the resident's Admission Nursing Assessment - Skin/Wound section did not assess the resident's wounds to her/his toes and foot. The resident was sent out to the hospital on 2/20/25 due to an infection.</p> <p>On 2/27/25 at 1:17 PM, Staff 2 (DNS) and Staff 4 (Wound Nurse/RN) acknowledged the lack of treatment and monitoring of Resident 101's wounds on 2/13/25 and 2/14/25, and was unable to provide documentation of wound care to the resident's other foot for 2/15/25.</p> <p>On 2/28/25 at 11:53 AM Resident 101 stated the nurses at the facility told her/him they did not receive an order for wound care so they would have to leave her/his wounds alone. About five days went by before the wound care nurse came and addressed the wound, but the wound had started to stink. Resident 101 state she/he knew her/his feet were infected and she/he almost lost a toe. Resident 101 stated staff never offered to change the bandages on the first day she/he was admitted and she/he never refused wound care. Resident 101 stated that she/he pleaded with staff to perform wound care because she/he knew she/he got infections easily.</p> <p>On 2/28/25 at 3:39 PM, Witness 2 (Wound Clinic Physician) indicated Resident 101 was his patient prior to and after her/his stay at the facility. On 2/20/25 the resident told him the facility had not completed wound care for four of the seven days the resident was at the facility and they only changed the outer dressing not the inner dressing. Witness 2 stated the resident had pain during dressing changes but never refused dressing changes. Witness 2 also stated burn wounds have a different physiology than other types of wounds. Infection was the main concern, and a lack of wound care can contribute to the development of an infection in the wound.</p> <p>2. Resident 102 was admitted to the facility in 2/2025, with diagnoses including fractured right femur and need for orthopedic aftercare (care following a fracture repair such as, physical therapy, pain management, and wound care).</p> <p>(continued on next page)</p>		

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 02/28/2025
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 102's 2/4/25 Nursing Progress Note indicated the resident admitted to the facility at approximately 2:10 PM, with a right femur fracture above the knee which was wrapped and a brace in place.</p> <p>Resident 102's Care Plan dated 2/11/25 indicated the resident was at risk for skin breakdown and pressure injury related to immobility from a recent femur fracture. Staff was to follow facility policies and protocols for the prevention and treatment of skin breakdown. On 2/27/25 the care plan was revised to include monitor the surgical incision to right knee and thigh for signs and symptoms of infection such as, increased pain, drainage, redness, odor, fever. Wound care provided every shift and notify nurse and MD if signs and symptoms occur.</p> <p>Resident 102's 2/2025 TAR included an order for staff to monitor surgical incision to the right knee and thigh for signs and symptoms of infection, increased pain, drainage, redness, odor, fever. Notify nurse and MD if symptoms occurred, every shift, for wound care. The order was dated 2/27/25, 23 days after the resident's admitted [DATE].</p> <p>Resident 102's electronic medical record revealed weekly skin evaluations were not completed, and had the following evaluations for the resident's three surgical sites as follows:</p> <p>-2/28/25: Skin & Wound Evaluation - front right knee (4 sutures)</p> <p>-2/28/25: Skin & Wound Evaluation - front right-side knee (3 sutures)</p> <p>-2/28/25: Skin & Wound Evaluation - front right thigh (2 sutures)</p> <p>On 2/27/25 at 10:36 AM, Staff 2 (DNS) and Staff 4 (Wound Nurse/RN) reviewed Resident 102's documentation and acknowledged the monitoring of the resident's surgical site did not begin until 2/27/25. Staff 4 indicated they were having trouble with hospitals not providing wound care instructions for residents and they were working to address the issue.</p> <p>3. Resident 103 was admitted to the facility in 2/2025, with diagnoses including fractured femur with a surgical site on the hip with staples.</p> <p>Resident 103's care plan dated 2/20/25 included the resident had potential for impairment to skin integrity related to surgical site on the hip with 13 staples. Staff were to monitor the hip for any changes to skin integrity. On 2/24/25 the care plan was revised to include staff were to monitor for pain, redness, and swelling to the site and report to nursing and MD.</p> <p>Resident 103's 2/2025 TAR included an order for staff to monitor the resident's right hip incisions for signs and symptoms of infection, BID. The order was dated</p> <p>2/27/25, 9 days after the resident's admitted .</p> <p>On 2/27/25 at 10:36 AM, Staff 2 (DNS) and Staff 4 (Wound Nurse/RN) reviewed the resident's documentation and acknowledged the monitoring of the resident's surgical site did not begin until 2/27/25. Staff 4 indicated they were having trouble with hospitals not providing wound care instructions for residents and they were working to address the issue.</p>		