

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  07/23/2025
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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on interview and record review, it was determined the facility failed to inform the resident prior to the initiation of a psychotropic medication for 1 of 3 sampled residents (#3). This placed residents at risk for not being informed of the side effects of a medication and not participating in their treatment. Findings include: Resident 3 admitted to the facility in 2/2025 with a diagnosis of seizures. Resident 3's Physician Order Details revealed she/he was administered the following psychotropic medications between 2/12/25 and 6/16/25:- Asenapine (prescribed to treat bipolar disorder)- Buspirone (prescribed to treat anxiety).- Lamotrigine (prescribed for seizures (can also be used for bipolar)). - Abilify (prescribed to treat bipolar). There was no documented evidence to show the resident was informed of the side effects of these medications prior to being administered. On 7/21/25 at 11:48 AM, Staff 14 (SSD) confirmed Resident 3 was not informed for the listed medications prior to the medication being administered. 7/23/25 at 10:45 AM, Staff 16 (Administrator), Staff 15 (DNS), and Staff 17 (Regional Nurse) were notified of the findings of Resident 3 not being informed, and no additional information was provided.</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>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview, and record review it was determined the facility failed to protect the resident's right to be free from sexual abuse by another resident for 1 of 3 sampled residents (# 6) reviewed for abuse. This placed residents at risk for mental anguish and abuse. Findings include: Resident 6 admitted to the facility in 2024, with diagnoses including diabetes and below the knee amputation. Resident 6's 6/25/25 Quarterly MDS revealed Resident 6 had a BIMS score of 15, which indicated the resident was cognitively intact. Resident 7 admitted to the facility in 2023, with diagnosis including cognitive communication deficit. Resident 7's 6/10/25 Quarterly MDS revealed Resident 7 had a BIMS score of 15, which indicated the resident was cognitively intact. On 6/16/25 a public complaint was filed which alleged Resident 7 made sexual contact with Resident 6 with a food item. On 7/16/25 at 9:47 AM, Resident 7 stated she/he gestured toward Resident 6 with a doughnut. Resident 7 did not recall saying anything afterward. Resident 7 stated Resident 6 had avoided her/him since the incident. On 7/17/25 at 9:46 AM, Witness 2 confirmed Resident 7 swiped a doughnut between Resident 6's legs. On 7/17/25 at 9:58 AM, Witness 1 stated her/his back was turned but Resident 6 was unable to speak, and the activities director was mad something happened. On 7/17/25 at 10:06 AM, Resident 6 stated she/he was sitting with two other residents and Staff 7 (Activity director) in the activity room eating doughnuts and drinking coffee. Resident 6 stated she/he playfully made a joke that she/he had touched all the doughnuts when Resident 7 reached for one. Resident 7 then took a doughnut, wiped it in her/his crotch area, ate it, and then stated now she/he had touched them all. Resident 6 stated, for a while after the incident she/he would check and see where Resident 7 was to avoid her/him. Resident 6 stated she/he was triggered by Resident 7's presence for at least a week after the incident. On 7/17/25 at 1:03 PM, Staff 7 (Activities Director) confirmed Resident 6 stated Resident 7 rubbed a doughnut between my legs. Staff 7 recalled Resident 6 turning white and getting quiet. Staff 7 confirmed an unwanted sexual incident occurred. On 7/18/25 at 8:37 AM, Staff 9 (CNA) stated after the incident Resident 6 was not herself/himself for about a week. Staff 9 indicated Resident 6 was angry about what happened. On 7/18/25 at 10:14 AM, Staff 13 (CNA) stated Resident 6 was angry and upset after the incident occurred. On 7/22/25 at 8:53 AM, Staff 18 (LPN) stated Resident 7 grabbed a doughnut and put it near Resident 6's private area. Staff 18 stated that Residents 6 and 7 were separated. Staff 18 confirmed the incident occurred.</p>