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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 01/28/2026 |
| 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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, it was determined the facility failed to ensure drinks were stored in accordance with professional standards for 1 of 2 resident refrigerators and failed to ensure water dispensers were properly sanitized for 1 of 1 water dispensers observed. This placed residents at risk for cross-contamination. Findings include: 1. On 1/16/26, the State Survey Agency received a public complaint indicating the filtered water stations had pink slime and were not replaced or cleaned. On 1/27/26 at 8:11 AM, the water dispenser across the hall from the main nurses' station was observed with an orangish buildup on the cold-water outlet and a gray to black buildup on the hot-water outlet. On 1/27/26 at 10:17 AM, Staff 8 (LPN) confirmed both water outlets on the dispenser had a buildup on the ends. On 1/28/26 at 8:44 AM, Staff 40 (Housekeeping Manager) stated the housekeeping department was responsible for cleaning and sanitizing the outside of the dispenser but not the outlets or the inside of the dispenser. On 1/28/26 at 9:19 AM Staff 44 (Maintenance Director) stated there was no cleaning schedule or documentation showing the water dispenser outlets were regularly cleaned. On 1/28/26 at 10:16 AM, Staff 1 (Administrator) stated he expected staff to complete the necessary activities for their job as required. 2. On 1/27/26 at 8:13 AM, the resident's snack refrigerator was observed to have three clear pitchers: one with a red liquid and two with yellow liquid. None of the pitchers had labels indicating when they were placed in the refrigerator or when they should be removed. On 1/27/26 at 10:17 AM, Staff 8 (LPN) confirmed the pitchers were not labeled. On 1/28/26 at 9:19 AM, Staff 39 (Dietary Manager) confirmed the pitchers of juice in the resident's snack refrigerator should have date labels. On 1/28/26 at 10:16 AM, Staff 1 (Administrator) stated he expected staff to complete the necessary activities for their job as required.</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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