STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385148	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royale Gardens Health & Rehabilitation Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review it was determined the facility failed to ensure water temperatures were safe, failed to implement fall risk interventions for 1 of 3 sampled residents (#83) reviewed for falls. As a result, Resident 83 experienced a fall and was hospitalized with subdural hematomas (a collection of blood in the brain causing pressure on the brain).1. Resident 83 was admitted to the facility in 12/2025 with diagnoses including dementia, anxiety, and fractured thigh bone.The 12/19/25 Nursing Wander Risk revealed Resident 83 was at risk for wandering. A 12/22/25 Progress Note revealed Resident 83 was not adjusting to the facility, was confused, and became agitated when redirected. The 12/24/25 admission MDS revealed Resident 83 had a BIMS score of 9 (moderately cognitively impaired) and multiple falls prior to her/his admission. Resident 83's CAAs indicated the resident had behaviors, poor safety awareness, dizziness, communication problems, wandered, and was incontinent which added to her/his risk for falls.The 12/31/25 Care Plan revealed Resident 83 was at risk for falls due to a recent fall with a bone fracture, balance problems and required one staff to assist with transfers. Resident 83 had behaviors and non-pharmaceutical interventions included to not force or rush care, and provide one on one and decrease over stimulation as neededThe 1/2026 Documentation Survey Report revealed Resident 83's behaviors included frustration, aggression towards others, and ambulation without assistance into the room of others on 1/1/2026. On 1/4/2026, Resident 83 threatened others, was agitated, and paced without staff assistance; no interventions were successful on either day to address the resident's behaviors. The facility's 1/4/26 Witnessed Fall-No Head Injury investigation, indicated Resident 83 was last seen at 1:20 PM in bed. Resident 83 stood up and held the windowsill without assistance. Staff 21 (CNA) saw the resident before she/he fell on the floor mat and hit her/his elbow. The facility's 1/4/26 Unwitnessed Fall investigation, indicated revealed Resident 83 was found sitting on the floor near her/his bed by Staff 16 (LPN). Resident 83 stated she/he hit her/his head. No injuries were noted at the time of the incident. Resident 83 was transported to the hospital for evaluation. The 1/7/26 Physician Discharge Summary revealed Resident 83 was admitted to the hospital following a fall at the facility resulting in head trauma. Resident 83 was lethargic when she/he arrived and a head scan revealed a critical left front subdural hematoma measuring up to 15 mm with additional subdural hematomas along the left and front of the brain. Resident 83 remained unresponsive during her/his hospitalization and a decision was made to transition to palliative care. On 3/11/26 at 9:44 AM, Staff 15 (CNA) stated Resident 83 had behaviors depending on the day and continued to try to pack to leave the building without assistance. Resident 83 required frequent checks before her/his fall in the facility and became angry when redirected.On 3/11/26 at 9:58 AM, Staff 11 (LPN) stated the use of one on one for Resident 83 was not implemented.On 3/12/26 at 10:55 AM, Staff 10 (LPN) stated Resident 83 was confused and restless which contributed to the resident's witnessed fall on 1/4/26 at 1:39 PM. On 3/12/26 at 8:36 AM, Staff 16 stated Resident 83 continued to state she/he hit her/his head after the unwitnessed fall on 1/4/26 at 7:45 PM. Staff 16 stated she sent Resident 83 to the hospital to minimize her concerns for the resident. On 3/12/26 at 9:16 AM, Staff 21 stated she observed Resident 83's first fall on 1/4/26. Staff 21 stated, on 1/4/26, Resident 83 required a second (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	staff for transfer safety during that shift due to her/his increased behaviors and lack of balance but only one staff was available. Resident 83 continued to attempt to self-transfer throughout the shift. Staff 21 stated there were no available staff to provide one-on-one for Resident 83. On 3/12/26 at 4:56 PM, Staff 3 (Unit Manger-LPN) provided a 1/2026 calendar noting the need to find one on one. Staff 3 acknowledged she was aware one-on-one was needed for Resident 83 especially since staff interventions to address behaviors and fall risks were unsuccessful. On 3/12/26 at 5:30 PM, Staff 2 (DNS) acknowledged one-on-one was needed for Resident 83 after the first fall on 1/4/26 and Staff 7 (Scheduling Coordinator) was unavailable to find staff.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview it was determined the facility failed to ensure call lights were operational for 4 of 4 sampled residents (#s 14, 22, 61, and 68) reviewed for call lights. This placed resident at risk for unmet needs. Findings include:1. Resident 14 was admitted to the facility in 1/2021 with diagnoses including pain.On 3/10/26 at 3:44 PM, Staff 32 (CNA) tested Resident 14's call light. When Staff 32 turned off Resident 14's call light, the roommate's call light also turned off.2. Resident 22 was admitted to the facility in 6/2024 with diagnoses including pain and repeated falls.The 12/19/25 Quarterly MDS revealed Resident 22 was cognitively intact.On 3/9/26 at 12:31 PM, Resident 22 stated it took staff approximately 20 minutes to answer her/his call light. Resident 22 stated she/he believed something was wrong with her/his call light, as it would shut off by itself. Resident 22 further stated she/he had reported this to staff; however, no follow-up occurred.On 3/10/26 at 3:42 PM, Staff 32 (CNA) stated Resident 22 had reported multiple times that her/his call light was not working; however, she initially believed the resident was mistaken. Staff 32 tested Resident 22's call light and confirmed it was not functioning properly. When Staff 32 turned off Resident 22's call light, the roommate's call light also turned off.3. Resident 61 was admitted to the facility in 1/2024 with diagnoses including stroke and diabetes.On 3/10/26 at 3:42 PM, Staff 32 (CNA) tested Resident 61's call light. When Staff 32 turned off Resident 61's call light, the roommate's call light also turned off.4. Resident 68 was admitted to the facility in 1/2023 with diagnoses including heart disease.On 3/10/26 at 3:50 PM, Staff 32 (CNA) tested Resident 14, Resident 22, Resident 61 and Resident 68's call lights with Staff 1 (Administrator) present. Staff 1 confirmed the call lights should operate independently.