

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  03/13/2026
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)
<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on interview and record review it was determined the facility failed to administer antibiotics for 1 of 1 sampled resident (#78) reviewed for hospitalization. As a result, Resident 78 was admitted to the hospital with a diagnosis of UTI. Findings include: Resident 78 was admitted to the facility in 1/2026 with a diagnosis of cancer. Resident 78's Progress Notes revealed the following:-1/6/26 Resident 78 had yellow/pink tinged urine in her/his Foley catheter drainage bag. Orders were received to hold Resident 78's blood thinner and blood work was to be obtained. -1/7/26 Resident 78's physician History and Physical Note revealed Resident 78 had cancer, and Resident 78 reported she/he hoped to live one year so she/he could return home. Resident 78 reported she/he did not want heroic effects and would elect hospice services if outlook was futile. -1/8/26 Resident 78's Foley catheter drained dark red urine. -1/9/26 Resident 78 had 500 ccs of bloody urine, she/he was alert and oriented, and she/he was transported to the hospital for evaluation and treatment. Resident 78's 1/9/26 hospital Emergency Department note revealed she/he was evaluated for blood in her/his urine. A urine sample was obtained and revealed the urine was cloudy, had blood present, white blood cells, and many bacteria. The note indicated the urine sample results demonstrated compelling evidence of infection. Resident 78 was discharged back to the facility, and the facility was to administer Ceftin (antibiotic) BID for two weeks. Resident 78's clinical record including her/his 1/2026 MAR revealed she/he was not administered antibiotics as prescribed from 1/9/26 through 1/13/26. Resident 78's Progress Notes revealed the following:-1/9/26 Resident 78 did not have blood in her/his urine-1/10/26 Resident 78 was alert, oriented, and did not have a Foley catheter. -1/11/26 and 1/12/26 Resident 78 did not have bloody urine.-1/13/26 Resident 78 was assessed to have a low blood pressure, increased heartrate, and had difficulty breathing. Resident 78 was transported to the hospital for evaluation. Resident 78's 1/17/26 hospital Discharge Summary revealed she/he was admitted to the hospital with evaluation and management of complicated UTI. Resident 78's admission diagnosis was UTI. On 3/12/26 at 11:20 AM, Staff 5 (LPN) stated when new orders were received, one nurse entered the orders into the resident's clinical record, and the unit manager was to verify the orders were entered correctly. On 3/13/26 at 8:29 AM, Staff 22 (LPN) stated he worked on 1/9/26 when Resident 78 returned from the emergency department with orders for an antibiotic. Staff stated he faxed Resident 78's orders to the pharmacy, but the orders were not transcribed into her/his clinical record. On 3/13/2026 11:01 AM, Staff 23 (Physician) stated Resident 78 had multiple comorbidities (distinct medical conditions or diseases occurring simultaneously in an individual making diagnosis and treatment more complicated) but the facility not administering her/his antibiotic likely contributed to her/his 1/13/26 hospitalization. On 3/12/26 at 1:14 PM, Staff 2 (DNS) stated staff did not correctly inter the 1/9/26 antibiotic order and the oncoming nurse did not look in the order box to ensure all orders were entered.</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 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 it was determined the facility failed to ensure the kitchen was kept in a sanitary manner in 1 of 1 kitchen reviewed for food service. This placed residents at risk for foodborne illness. Findings include: On 3/11/26 at 12:19 PM, during an observation of the kitchen, a swamp cooler located above the stove and food preparation area had a visible buildup of dust. A black pipe extending from the ceiling near the swamp cooler appeared greasy with dust accumulation. On 3/11/26 at 12:20 PM, Staff 29 (District Manager) and Staff 30 (Dietary Manager) confirmed the swamp cooler should have been clean.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observation and interview it was determined the facility failed to ensure their call light communication system functioned independently for each resident in a shared room for 4 of 4 sampled residents (#s 14, 22, 61, and 68) reviewed for call lights. This placed residents 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 because it would shut off by itself. Resident 22 further stated she/he reported this to staff; however, no follow-up occurred.On 3/10/26 at 3:42 PM, Staff 32 (CNA) stated Resident 22 reported multiple times that her/his call light was not working. However, she initially believed the resident was mistaken and did not address it. Staff 32 tested Resident 22's call light and confirmed it was not functioning properly because when Staff 32 turned off Resident 22's call light, the roommate's call light also turned off.On 3/11/26 at 10:24 AM, Staff 25 (CNA) stated she observed the issues with the call light system for several years. Staff 25 stated she informed staff about the call lights not functioning properly, but the concerns had not been resolved.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 each resident's call light should operate independently.</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>Based on interview and record review it was determined the facility failed to ensure the resident and resident representative were included in the care planning process for 1 of 3 sampled residents (#5) reviewed for care planning. This placed residents at risk for insufficient involvement in care decisions. Findings include: Resident 5 was admitted to the facility in 11/2023 with diagnoses including brain damage and heart failure. A 10/17/23 legal Petition for Appointment or a Temporary Guardian and Permanent Guardian of An Adult revealed Witness 2 (Family Member) was Resident 5's legal guardian. A 2/17/25 IDT (Interdisciplinary Team) Care Plan Conference/Welcome Meeting Form revealed Resident 5 and Witness 2 attended the meeting and were involved in the care planning development. The 11/17/25 Annual MDS indicated Resident 5 was unable to participate in her/his BIMS assessment. On 3/9/26 at 2:52 PM, Witness 2 stated he was not included in any recent care planning process and had questions about Resident 5's therapy and nutrition. On 3/10/26 at approximately 4:30 PM, Staff 8 (Regional Director of Clinical) confirmed Resident 5's last care conference was on 2/17/25. On 3/12/26 at 11:29 AM, Staff 5 (Director of Social Services) stated she was recently hired and was working to address the lack of timely care conferences for residents. Staff 5 expected care conferences to occur quarterly and annually, family needed to be invited to care conferences, and acknowledged Resident 5's last care conference was a long time ago.</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observation, interview, and record review it was determined the facility failed to ensure a resident was assessed to self-administer medications for 1 of 4 sampled residents (#10) reviewed for accidents. This placed residents at risk for an adverse medication regimen. Findings include: Resident 10 was admitted to the facility in 5/2020 with a diagnosis of heart disease. Resident 10's 8/11/23 Self-Administration of Medication form revealed Resident 10 wanted to self-administer medications, did not have visual impairment, was alert and oriented, and was assessed to be safe to self-administer medications. The form did not list which medications Resident 10 was safe to administer. Resident 10's 2/28/26 Quarterly MDS revealed she/he was cognitively intact. Resident 10's 3/2026 MAR revealed she/he was able to self-administer artificial tears BID. The MAR also revealed Resident 10 administered the medication BID. On 3/9/26 at 1:00 PM, observation revealed fluconazole (an antifungal medication) nasal spray, an over the counter hair growth supplement, an over the counter weight loss medication, and a non-medicated eye drop on Resident 10's bedside table. On 3/10/26 at 12:16 PM, Staff 12 (LPN) stated if a resident had medications at the bedside, staff were to first assess the resident to ensure they were capable of medication self-administration. Staff 12 also stated the medications were to be stored in a safe manner such as in a lock box. Staff 12 stated Resident 10 had orders for the self-administration of eye drops, but did not have orders for the fluconazole, weight loss medication, or hair growth supplement. On 3/10/26 at 12:34 PM, Staff 2 (DNS) stated no residents were currently identified to be able to self-administer medications. Staff 2 stated staff should have identified the medications were at the bedside and assessed Resident 10 to ensure she/he was capable of self-medication administration. On 3/11/26 at 11:54 AM, Resident 10 stated she/he had the medications at her/his bedside forever.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>Based on interview and record review it was determined the facility failed to ensure residents received showers for 1 of 4 sampled residents (#36) reviewed for ADLs. This placed residents at risk for poor hygiene. Findings include: Resident 36 was admitted to the facility in 12/2025 with diagnoses including a below knee amputation of the right leg and a diabetic ulcer of the left foot. A 12/31/25 admission MDS indicated Resident 36 was cognitively intact with a BIMS score of 14. A 1/5/26 Care Plan for Resident 36 lacked information regarding bathing/showering. On 3/9/26 at 2:22 PM, Resident 36 stated she/he did not receive showers as frequently as was her/his preference, and she/he was told by CNAs this was due to lack of staff to help with showers. The Kardex (abbreviated care plan for CNAs) as of 3/10/26 for Resident 36 did not include the level of assistance required by Resident 36 for bathing. According to the Documentation Survey Report for 2/2026 and 3/2026, Resident 36 received three out of eight showers during the month of 2/2026. On 3/11/26 at 9:24 AM, Resident 36 stated frustration with the lack of opportunities to shower and stated, It's not like I need help; I just need to be wheeled in there and wheeled out after. On 3/11/26 at 10:16 AM, Staff 13 (CNA) stated when CNAs were short-handed, showers were frequently not completed. On 3/12/26 at 7:42 AM Staff 39 (CNA) confirmed evening shift CNA staff often ran out of time in their shift to provide showers to residents. On 3/12/26 at 4:13 PM, Staff 2 (DNS) indicated that a shower schedule was posted at the nurse's station with two scheduled showers per week per resident, unless a resident preferred one. Staff 2 confirmed the number of showers Resident 36 received failed to meet facility expectations. Staff 2 acknowledged CNA staff voiced difficulty completing assigned care and scheduled showers.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>Based on observation, interview, and record it was determined the facility failed to provide meaningful activities for a dependent resident for 1 of 2 sampled residents (#5) reviewed for activities. This place residents at risk for lack of social interaction and isolation. Findings include: Resident 5 was admitted to the facility in 11/2023 with diagnoses including brain damage and heart failure. The 11/17/25 Annual MDS indicated Resident 5 was unable to participate in her/his BIMS assessment and her/his activity preferences were completed by staff. Staff indicated Resident 5 liked to listen to music and attend group activities. The Activities CAA revealed appropriate activities were needed to help protect the resident from social isolation and loneliness. A 2/27/26 revised Care Plan indicated Resident 5 required assistance to activity functions, she/he preferred to socialize with staff members and was able to sit in her/his chair to watch movies. Resident 5's preferred activities including watching comedy in her/his chair. Resident 5's care plan did not indicate any music as a preference. The 3/10/26 CNA Task: Activity Involvement report revealed on 2/16/26 Resident 5 received a single one to one conversation during the last 30 days. No other activities were indicated. On 3/10/26 at 10:57 AM, Resident 5 was observed in bed with her/his television on and no engagement with staff. On 3/10/26 at 1:59 PM, Resident 5 was observed in bed awake and looking at that wall. On 3/10/26 at 2:39 PM, Staff 14 (CNA) stated Resident 5's family visited infrequently. On 3/11/26 at 11:04 AM, Resident 5 was in her/his bed with the television on and no social engagement. On 3/11/26 at 10:50 AM, Staff 4 (Activities Assistant) stated he was instructed to engage cognitively impaired residents once each month and believed the requirement for Resident 5's activities were met. Staff 4 was not aware Resident 5's family visited infrequently and stated residents who had infrequent family interactions were to have increased interaction. Staff 4 stated he lacked training to address the needs of cognitively impaired residents and was currently the only staff working in the activities department. On 3/11/26 at 1:09 PM, Staff 17 (CNA) stated Resident 5 rarely was in her/his chair and only Staff 9 (CNA) was successful to ensure the resident did not get agitated when assisted into her/his chair. ON 3/11/26 at 3:34 PM, Staff 9 stated he did not care for Resident 5 often and was able to motivate Resident 5 with her/his preference for music and conversation during care. Staff 5 stated he played Resident 5's music preference on his own equipment because music was not set-up in the resident's room. On 3/11/26 at 5:46 PM, Staff 3 (Unit Manger-LPN) stated staff required additional training. Staff 3 expected staff to assist and offer daily activities to residents who were bedbound and acknowledged Resident 5's care plan required updated information to include her/his preference for music.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>Based on interview and record review it was determined the facility failed to provide adequate ROM services for 2 of 3 sampled residents (#s 5 and 45) reviewed for position and mobility. This placed residents at risk for compromised mobility and pain. Findings include:1. Resident 5 was admitted to the facility in 11/2023 with diagnoses including brain damage and heart failure.</p> <p>A 4/30/24 Restorative Nursing Program Plan indicated Resident 5's restorative treatment was to occur one to three times each week and interventions included bilateral upper and lower extremity exercises to her/his shoulder, elbow, wrist, hand, hip, knee and ankle.</p> <p>The 11/17/25 Annual MDS indicated Resident 5 was unable to participate in her/his BIMS assessment and received ROM services for five out of seven days during the review period with no therapy services.</p> <p>The 1/1/26 through 3/8/26 Restorative Program log for Resident 5 revealed from 1/10/26 through 1/20/26 (11 days) and 2/15/26 through 2/21/26 (seven days) ROM services were NA (not available).</p> <p>The 2/17/26 Quarterly MDS revealed Resident 5 received ROM services one day out of seven during the review period.</p> <p>A 2/27/26 revised Care Plan indicated Resident 5 was non-verbal and had a performance deficit due to impaired mobility and bilateral upper extremity ROM impairment. The nursing and rehabilitation active ROM program was to maintain progress from therapy and be conducted one to five times each week.</p> <p>On 3/10/26 at 2:39 PM, Staff 14 (CNA) stated she provided ROM exercises to residents in the past but, during the last two months, she no longer provided ROM to residents. Staff 14 stated if CNAs were not trained to provided ROM exercises, CNAs were not to perform the task.</p> <p>On 3/10/26 at 3:49 PM, Staff 12 (LPN) stated she no longer saw staff provide ROM services for Resident 5 until 3/2026 when therapy began to work with Resident 5's hands.</p> <p>On 3/11/26 at 9:18 AM, Staff 18 (Director of Therapy) stated Resident 5 was re-evaluated in 10/2025 and she expected CNAs to provide ROM services if a designated restorative aide was unavailable. Staff 18 stated Resident 5 required ongoing ROM services.</p> <p>On 3/13/26 at 8:27 AM, Staff 19 (PT) acknowledged, over the last two to three months, ROM services for residents had declined despite the need for ROM services to assist residents with therapy maintenance. Staff 19 stated Resident 5's lack of consistent ROM services impacted her/his ease with transfers.</p> <p>On 3/13/26 at 3:01 PM, Staff 2 (DNS) stated a decision was made to remove restorative aide hours from the schedule to CNA hours during the last two months. Staff 2 expected ROM services to be consistent for Resident 5 and other residents who required ROM services.</p> <p>2. Resident 45 admitted to the facility in 11/2020 with diagnoses including pain and contractures of muscle of left and right hand. (continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 10/14/25 ADL Care Plan indicated Resident 45 had a self-care performance deficit related to contractures. Staff were to provide restorative therapy consisting of active range of motion exercises to the bilateral upper extremities for 10 repetitions per extremity using a 3-pound weight, and active range-range-of motion exercises to the bilateral lower extremities for 10 repetitions while the resident's seated in a wheelchair.</p> <p>The 12/30/25 Quarterly MDS revealed Resident 45 was cognitively intact, had impairment on all four extremities, was dependent on staff for ADLs, and received range of motion services three days out of seven during the review period.</p> <p>Review of Resident 45's clinical record found no documented evidence a restorative program was being provided.</p> <p>On 3/9/26 at 3:21 PM, Resident 45 stated she/he previously received restorative therapy but was told they did not have enough staff to continue providing restorative services. Resident 45 reported restorative therapy helped strengthen her/his arms, shoulders, and hands, and stated since the therapy stopped, she/he had experienced increased tightness in her/his arms.</p> <p>On 3/11/26 at 10:24 AM, Staff 25 (CNA) stated Resident 45's hands were contracted. Staff 25 confirmed the facility did not have a restorative program for more than three months because staff were pulled from the floor. Staff 25 further stated Resident 45 had previously participated in the restorative therapy program and she/he asked whether the services would be continued.</p> <p>On 3/11/26 at 11:50 AM, Staff 26 (CNA) stated the facility had not had restorative services for some time.</p> <p>On 3/11/26 at 2:28 PM, Staff 27 (CNA) stated the facility had not had a restorative aid program for the past six months.</p> <p>On 3/12/26 at 10:20 AM, Staff 28 (Physical Therapy) stated the facility had not had a restorative program the past few months. Staff 28 further stated when services were provided, Resident 45 actively participated and benefited from the services.</p> <p>On 3/12/26 at 11:49 AM, Staff 1 (Administrator) acknowledged the facility did not have a restorative program and expected restorative services be provided.</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>Based on interview and record review it was determined the facility failed to ensure x-rays were obtained timely for 1 of 6 sampled residents (#10) reviewed for accidents. This placed residents at risk for delayed treatment. Findings include: Resident 10 was admitted to the facility in 5/2020 with a diagnosis of heart disease. Resident 10's Progress Notes revealed the following:-11/4/25 staff responded to Resident 10's call for help. Resident 78 was found on the floor and reported bilateral feet pain. knee pain, and hip pain. The note indicated x-rays were obtained. Resident 10's 11/4/26 Order Details revealed left ankle, right ankle, left toes, right toes, left knee, right knee, hips and pelvic x-rays were orders. Resident 10's clinical record revealed results of her/his 11/4/25 right foot/ankle x-rays results were not in her/his clinical record. Resident 10's Progress notes revealed the following: -11/7/25 Resident 10 had bruising and swelling to her/his right foot.-11/9/25 Resident 10 was offered to be transported to the hospital for evaluation but declined.-11/11/25 Resident 10 had unrelieved pain and her/his physician was notified-11/28/25 Resident 10 had a discolored swollen area to the right lower shin, foot and inner ankle. Resident 10's physician was notified and right ankle x-rays were ordered. Resident 10's 11/28/25 x-ray report revealed her/his right ankle was fractured. On 3/11/26 at 5:15 PM, Staff 24 (LPN) stated she was at the facility when Resident 10's 11/4/25 x-rays were obtained. The x-ray technician did not ask for staff assistance with positioning and when the technician left, he did not indicate any of the ordered x-rays were not obtained. Staff 24 stated if she would have been notified the x-rays were not completed as ordered, she would have notified Resident 10's physician. On 3/11/26 at 12:42 PM, Staff 3 (LPN Unit Manager) stated Resident 10's right foot x-rays were not obtained as ordered on 11/4/25. On 3/13/26 at 2:20 PM, Staff 2 (DNS) stated the x-ray t technician did not report he did not obtain the ordered 11/4/25 right ankle x-rays. When Resident 10's physician reviewed all the x-rays, it was not noted the right foot x-rays were not completed.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review the facility failed to ensure the resident's clinical record accurately reflected the resident's resuscitation wishes for 1 of 4 sampled residents (#44) reviewed for ADLs. This placed residents at risk for not having their resuscitation choices followed. Findings include: Resident 44 was admitted to the facility [DATE] with a diagnosis of chronic heart failure. A review of the resident's clinical record revealed a POLST (Portable Order of Life-Sustaining Treatment) dated [DATE] indicating the resident elected a designation of Do Not Attempt Resuscitation (DNR).A review of the resident's IDT Care Plan Conference revealed the resident elected to be designated as DNR.A review of the resident's Clinical Resident Profile revealed the resident was to receive CPR. On [DATE] at 6:55 AM, Staff 11 (LPN) stated nurses are responsible for entering the resident's CPR/DNR status into the residents' clinical record. Staff 11 confirmed Resident 8's Clinical Resident Profile revealed the resident elected to receive CPR but her/his POLST revealed a status of DNR. Staff 11 stated if a resident was found unresponsive staff would look at the Clinical Profile to know whether or not to attempt CPR. On [DATE] at 3:17 PM, Staff 2 (DNS) stated her expectation was the clinical record would reflect the resident's elected resuscitation status.</p>		