STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415040	A. Building B. Wing	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Middletown Nursing Center	193 Forest Avenue Middletown, RI 02842

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21613 Based on record review, and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice relative to following physician's orders for 1 of 3 residents reviewed relative to medication administration, Resident ID #1. Findings are as follows: Record review of a community reported complaint submitted to the Rhode Island Department of Health on 10/2/2024, alleges the resident has high phosphorus level (can causes damage to body and/or weaken bones) and is supposed to receive Xphozah (a medication prescribed to lower serum phosphorus levels for residents with chronic kidney disease who receive dialysis), but has not received the medication yet. According to Mosby's 4th Edition, Fundamentals of Nursing page 314, which states in part, The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Record review revealed that the resident was readmitted to the facility in September of 2024 with diagnoses including, but not limited to, brain damage, dementia, and end stage renal disease. Record review of the Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 9 out of 15, indicating the resident has moderate cognitive impairment. Record review revealed a physician's order dated 1/31/2024 for dialysis 3 times a week on Tuesday, Thursday, and Saturday, with a 5:00 AM pick up time. Record review of a care plan revised on 9/20/2024, revealed the resident is on dialysis and medications are to be administered, as ordered. Record review of a laboratory report dated 9/25/2024 revealed, the resident's phosphorus level was elevated with a result of 8 milligrams/milliliters (mg/ml). A normal phosphorus level is 2.5-4.5 mg/ml. Record review of a dialysis communication record dated 9/26/2024 revealed, a recommendation to administer Xphozah 30 mg tablet, give 1 tablet two times daily. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further record review revealed a physician's order was obtained on 9/26/2024 for Xphozah 30 mg tablet, give 1 tablet orally two times a day related to dependence on renal dialysis, at breakfast and dinner. Record review of the Medication Administration Record for October 2024 failed to reveal evidence that the Xphozah was administered on the following dates: -10/3/2024 at dinner -10/4/2024 at breakfast -10/5/2024 at breakfast -10/6/2024 at breakfast -10/8/2024 at breakfast During a surveyor interview on 10/8/2024 at 9:16 AM with a Medication Technician, Staff A, he revealed the resident has dialysis 3 times a week. Staff A revealed the resident leaves the facility between 5:00 AM - 5:30 AM and returns to the facility between 11: 45 AM - 12:00 PM. Staff A further revealed the resident eats her/his breakfast before s/he leaves the facility. During a surveyor interview on 10/8/2024 at approximately 1:00 PM with Registered Nurse, Staff B, she revealed that she was unaware that the resident did not received Xphozah with his/her breakfast this morning. Additionally, Staff B revealed she was unaware that the resident was not administered Xphozah on the above dates. During a surveyor interview on 10/8/2024 at 1:20 PM with the resident, s/he revealed s/he does not know what medications s/he is supposed to take because s/he takes whatever they give him/her. During a surveyor interview on 10/8/2024 at 2:30 PM with the Director of Nursing Services, she was unable to provide evidence that the resident was administered Xphozah as ordered on 10/3/2024 at dinner, 10/4/2024 at breakfast, 10/5/2024 at breakfast, 10/6/2024 at breakfast, and 10/8/2024 at breakfast.