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	04/02/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43987 Based on record review, resident and staff interview, it has been determined that the facility failed to ensure that all alleged violations involving physical abuse are thoroughly investigated for 1 of 1 resident reviewed, Resident ID #31. Findings are as follows: Review of a facility policy titled, .Abuse Policy states in part, .It is the policy of this facility to take appropriate steps to prevent the occurrence of abuse .and ensure that all alleged violations of Federal and State laws . are reported immediately to the Executive Director of the facility .The facility will investigate each alleged violation thoroughly and report the results of the investigations to the Executive Director .Policy and procedure .The supervisor is to initiate the following steps: a. Immediate investigation into the alleged incident. b. Interview staff member implicated. Get a written statement. c. Interview other staff members. Employee should document incident in a written narrative. d. Interview with resident or resident witness. Supervisor to document incident in a written statement from resident (s) . i. Notify the Social Worker who will interview the resident . Definitions .Abuse: Unjustified physical contact, intentional and careless, which is likely to result in physical or psychological harm .The law is: Each resident has the right to be free from abuse .Residents must not be abused by anyone, including staff .Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish . Review of a facility reported incident sent to the Rhode Island Department of Health on 3/24/2025 alleges that the resident reported that a Nursing Assistant (NA) grabbed his/her right forearm tightly and told him/her that s/he needs to get washed up whether s/he likes it or not. (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: 415040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Royal Middletown Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 193 Forest Avenue Middletown, RI 02842	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed the resident was admitted to the facility in January of 2025 with diagnoses including, but not limited to, dementia, anxiety and depression. Review of a Quarterly Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 9 out of 15, indicating moderate cognitive impairment. Additional review of the assessment revealed that s/he self-propels with a wheelchair and requires moderate assistance for activities of daily living. Record review of a progress note dated 3/24/2025, authored by Registered Nurse, Staff B, indicates the resident reported that s/he was sitting in his/her wheelchair when NA, Staff A, grabbed [his/her] right forearm tightly and told him/her that s/he needs to get washed up whether [s/he] wants to or not. Staff A then attempted to pull the resident out of the wheelchair. The resident appeared frightened and reported right arm discomfort. Further record review failed to reveal evidence that Staff A was interviewed by the facility after the incident, until it was brought to the facility's attention by the surveyor. Additionally, the record failed to reveal evidence that any interviews were conducted by the facility as part of the investigation, including, but not limited interviewing Staff B. During surveyor interviews on 4/1/2025 at 1:10 PM and approximately 3:00 PM with the Director of Nursing Services (DNS), she revealed that on 3/24/2025 she was made aware that Staff A was behaving strange and appeared impaired, sitting on the floor and not responding to call lights. Additionally, the DNS revealed that she did not conduct an interview with Staff A or any other staff member to investigate the alleged incident. Additionally, the DNS provided the surveyor Staff A's written statement regarding the incident that she had just obtained when the surveyor was present in the building and questioning the incident. Staff A's statement indicated that on the night of the incident, Staff A had grabbed the resident's hand to attempt to provide care, the resident refused care and Staff A never returned to the resident's room. Further the DNS was unable to provide any further documentation relative to the investigation. An attempt was made by the surveyor, to interview Staff A on 4/2/2025, but the surveyor did not receive a return call. 45855 \