

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  11/25/2025
NAME OF PROVIDER OR SUPPLIER  Royal Middletown Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0684  Level of Harm - Actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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

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F 0684  Level of Harm - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation, record review, and staff interview, the facility failed to; obtain, review, and report laboratory tests, as ordered; notify a provider of abnormal or missing test results; and complete ordered COVID-19 testing upon admission and subsequent days for 2 of 3 newly admitted residents reviewed, Resident ID #s 1 and 2. The facility's failure involved UTI-related laboratory testing and follow-up, that resulted in a delay of care, including the hospitalization of Resident ID #1. Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/18/2025 alleged in part that the facility had a Covid-19 outbreak, and that Resident ID #1 was now positive for Covid-19. The complaint further alleged that the resident had blood in his/her urine and was not receiving care that s/he should. 1. Record review revealed Resident ID #1 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, urinary tract infection (UTI) and neuromuscular dysfunction of the bladder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed, the resident had a urostomy (a surgical opening in the abdomen to allow urine to exit the body). Further review revealed the resident required moderate assistance with activities of daily living. Record review of a care plan dated 11/13/2025 revealed, Resident ID #1 is at risk for infection related to a left Percutaneous Nephrostomy Tube (PCN, a tube that is surgically placed into the kidney to allow urine to drain out of the body) and right urostomy with interventions including, but not limited to; monitor, document, and report abnormal lab values, as ordered. 1a. Record review of the physician's order revealed the following:- 11/6/2025, to obtain labs including a complete blood count, (CBC) and complete metabolic panel (CMP) on 11/10/2025.- 11/12/2025 to obtain a urinalysis, culture and sensitivity (UA C&amp;S- urine tests prescribed to detect UTIs and guide appropriate treatment). Record review failed to reveal evidence that the physician's order for a CBC was transcribed to be completed. Additionally, further review failed to reveal evidence that the labs were obtained on 11/10/2025, as ordered. Record review of the laboratory results revealed the UA was obtained on 11/12/2025 and resulted on 11/14/2025. Further review revealed Resident ID #1 was positive for a UTI. Record review of the progress notes failed to reveal evidence that the UA C&amp;S results were reported to a provider, or that an intervention was put into place. Further review revealed the resident was transferred to the hospital on [DATE] for an evaluation of shortness of breath, cough, and blood in his/her urostomy and PCN tube. 1b. Review of the COVID-19 Testing Informed Consent Form which states in part, I understand I will be tested upon admission. revealed Resident ID #1 signed the consent form on 11/6/2025. Record review revealed a physician's order dated 11/8/2025 stating, [Covid-19] Test new admissions or residents who have left the facility for more than 24 hours, regardless of vaccination status, on admission, day 2 and day 4. Record review failed to reveal evidence that Resident ID #1 was tested for Covid on admission, on day two, or on day four, as ordered. Record review of the hospital documentation dated 11/17/2025 revealed, the resident was admitted to the hospital with diagnoses including, but not limited to, a UTI and Covid. Further review of hospital documentation revealed that as of 11/24/2025, Resident ID #1 remained in the hospital. During a surveyor interview on 11/24/2025 at approximately 11:00 AM with Registered Nurse (RN), Staff A, she indicated that the facility currently has a Covid-19 outbreak, which began on 11/17/2025. She further indicated that every resident should be tested for Covid on admission, on day two, and on day four. Additionally, she acknowledged that Resident ID #1 had not been tested for Covid-19 at all while admitted to the facility. Furthermore, she acknowledged that the labs were not completed on 11/10/2025, as ordered, and that the positive UA C&amp;S results on 11/14/2025 were not reported to a provider. During a surveyor interview on 11/24/2025 at approximately 1:45 PM, with the Infection Preventionist, she acknowledged that the labs were not completed on 11/10/2025, as ordered. She further acknowledged that Resident ID #1 was not tested for Covid on admission, on day two, or on day four, and that the facility currently has a Covid-19 outbreak. Additionally, she indicated that the UA C&amp;S results, dated 11/14/2025, were not viewed by any facility staff until 11/17/2025, the day the resident was sent to the hospital for shortness of breath, blood in his/her urostomy, and PCN tube. Furthermore, she acknowledged that a provider was not notified of the results and that interventions were not put into place. 2. Record review showed Resident #2 was admitted in November 2025 with diagnoses including a history of UTIs and muscle weakness. Review of a care plan dated 11/19/2025 revealed, the resident had a UTI with interventions including, but not limited to, to obtain and monitor lab results as ordered. 2a. Record review of the physician's order revealed the following:-</p>		

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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 0880  Level of Harm - Actual harm  Residents Affected - Some	Provide and implement an infection prevention and control program.  (continued on next page)

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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on surveyor observation, record review, and staff interview, the facility failed to; obtain, review, and report laboratory tests, as ordered, and complete ordered COVID-19 testing upon admission and on subsequent days for 2 of 3 newly admitted residents reviewed, Resident ID #s 1 and 2. The facility's failure involved urinary tract infection (UTI) related laboratory testing and follow-up, and the failure to obtain Covid-19 testing, as ordered, resulted in a delay of care, including the hospitalization of Resident ID #1 with diagnoses including Covid-19 and a UTI. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 11/18/2025 alleged in part that the facility had a Covid-19 outbreak, and that Resident ID #1 was now positive for Covid-19. The complaint further alleged that the resident had blood in his/her urine and was not receiving care that s/he should.1. Record review revealed Resident ID #1 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, UTI and neuromuscular dysfunction of the bladder. Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed, the resident had a urostomy (a surgical opening in the abdomen to allow urine to exit the body). Further review revealed the resident required moderate assistance with activities of daily living. Record review of a care plan dated 11/13/2025 revealed, Resident ID #1 is at risk for infection related to a left Percutaneous Nephrostomy Tube (PCN, a tube that is surgically placed into the kidney to allow urine to drain out of the body) and right urostomy with interventions including, but not limited to; monitor, document, and report abnormal lab values, as ordered.1a. Record review of the physician's order revealed the following:- 11/12/2025 to obtain a urinalysis, culture and sensitivity (UA C&amp;S- urine tests prescribed to detect UTIs and guide appropriate treatment).Record review of the laboratory results revealed the UA was obtained on 11/12/2025 and resulted on 11/14/2025. Further review revealed Resident ID #1 was positive for a UTI. Record review of the progress notes failed to reveal evidence that the UA C&amp;S results were reported to a provider, or that an intervention was put into place. Further review revealed the resident was transferred to the hospital on [DATE] for an evaluation of shortness of breath, cough, and blood in his/her urostomy and PCN tube.1b. Review of the COVID-19 Testing Informed Consent Form states in part, I understand I will be tested upon admission. revealed Resident ID #1 signed the consent form on 11/6/2025. Record review revealed a physician's order dated 11/8/2025 stating, [Covid-19] Test new admissions or residents who have left the facility for more than 24 hours, regardless of vaccination status, on admission, day 2 and day 4. Record review failed to reveal evidence that Resident ID #1 was tested for Covid on admission, on day two, or on day four, as ordered.Record review of the hospital documentation dated 11/17/2025 revealed, the resident was admitted to the hospital with diagnoses including, but not limited to, a UTI and Covid. Further review of hospital documentation revealed that as of 11/24/2025, Resident ID #1 remained in the hospital. During a surveyor interview on 11/24/2025 at approximately 11:00 AM with Registered Nurse (RN), Staff A, she indicated that the facility currently has a Covid-19 outbreak, which began on 11/17/2025. She further indicated that every resident should be tested for Covid on admission, on day two, and on day four. Additionally, she acknowledged that Resident ID #1 had not been tested for Covid-19 at all while admitted to the facility. Furthermore, she acknowledged that the positive UA C&amp;S results on 11/14/2025 were not reported to a provider and the resident had not been treated at the facility prior to his/her hospitalization. During a surveyor interview on 11/24/2025 at approximately 1:45 PM, with the Infection Preventionist, she acknowledged that Resident ID #1 was not tested for Covid on admission, on day two, or on day four, and that the facility currently has a Covid-19 outbreak. Additionally, she indicated that the UA C&amp;S results, dated 11/14/2025, were not viewed by any facility staff until 11/17/2025, the day the resident was sent to the hospital for shortness of breath, blood in his/her urostomy, and PCN tube. Furthermore, she acknowledged that a provider was not notified of the results and that interventions were not put into place. 2. Record review revealed Resident #2 was admitted in November 2025 with diagnoses including a history of UTIs and muscle weakness. Review of a care plan dated 11/19/2025 revealed, the resident had a UTI with interventions including, but not limited to, to obtain and monitor lab results, as ordered.2a. Record review of the physician's order revealed the following:- 11/19/2025 to obtain a UA C&amp;SRecord review failed to reveal evidence that the UA C&amp;S was completed as ordered. 2b. Record review revealed a physician's order dated 11/13/2025 to [Covid-19] Test new admissions or residents who have left the facility for more than 24 hours, regardless of vaccination status, on admission, day 2 and day 4 Record review failed to reveal evidence that</p>		