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	01/07/2026

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. Based on clinical record review and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 1 resident reviewed for blood pressure medications with parameters, Resident ID #3.Findings are as follows:Review of a facility policy titled, Medication Administration Policy, last revised February of 2025, states in part, .Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.Record review revealed the resident was admitted to the facility in November of 2025 with diagnoses including, but not limited to, hypertension (high blood pressure) and atrial fibrillation (irregular heartbeat).Review of a care plan focus area initiated on 11/25/2025 revealed, the resident has hypertension. Interventions include, administer hypertension medication, as ordered; obtain vital signs as ordered, and monitor/document/report any signs or symptoms of hypertension.Record review revealed a physician's order dated 12/7/2025 for metoprolol tartrate oral tablet (a blood pressure medication), 100 milligrams (mg) twice daily for hypertension, with instructions to hold for a systolic blood pressure (SBP, the top number in a blood pressure reading, which indicates the pressure in your arteries when your heart beats) less than 110 or a heart rate (HR) less than 60.Record review revealed a physician's order dated 12/7/2025 for amiodarone HCl oral tablet (an antiarrhythmic medication), 200 mg once daily, related to atrial fibrillation and hypertension, with instructions to hold for a HR less than 60.Review of the December 2025 and January 2026 Medication Administration Records (MARs) revealed the resident's metoprolol was documented as being administered, when his/her heart rate was below the indicated parameter, on the following dates and times:-12/10/2025 at 5:00 PM, with a HR of 52-12/12/2025 at 8:00 AM, with a HR of 58-12/12/2025 at 5:00 PM, with a HR of 49-12/16/2025 at 5:00 PM, with a HR of 48-12/17/2025 at 5:00 PM, with a HR of 51-1/2/2026 at 5:00 PM, with a HR of 54-1/6/2026 at 5:00 PM, with a HR of 57Review of the December 2025 MAR revealed that on 12/12/2025, the amiodarone was documented as being administered when the resident's heart rate was 58, which is below the indicated parameter.During a surveyor interview on 1/7/2026 at 12:48 PM, with Certified Medication Technician (CMT), Staff A, he revealed that vital signs are obtained prior to administering the resident's metoprolol or amiodarone, to ensure the resident's vital signs are within the indicated parameters. He acknowledged that the documentation in the MAR indicated the medication was administered on the above-mentioned dates and revealed that he would not have administered the resident his/her metoprolol or amiodarone, as the resident's HR was below the indicated parameter. Further, he revealed that if the medications are held due to the residents' vital signs, the CMT should notify the nurse. Review of the December 2025 MAR revealed the resident's metoprolol was held 13 out of 28 opportunities due to his/her HR being below the indicated parameter. Additional review revealed 5 opportunities, listed above, where the resident's metoprolol was documented as being administered outside of the parameters and should have been held, indicating a total of 18 out of 28 opportunities where the resident's HR (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was below the parameters.Review of the January 2026 MAR revealed 2 out of 13 opportunities, the resident's metoprolol was held due to his/her HR being below the indicated parameter. Additional record review revealed 2 opportunities, listed above, where the resident's metoprolol was documented as being administered outside of the parameters and should have been held, indicating a total of 4 out of 13 opportunities where the resident's HR was below the parameter.Record review failed to reveal evidence that the resident's provider was notified of the multiple held doses of metoprolol, due to the resident's low HR.During a surveyor interview on 1/7/2026 at 12:54 PM, with Registered Nurse, Staff B, she revealed that if the resident's metoprolol or amiodarone was held due to his/her vital signs, the CMT would inform the nurse. She acknowledged that the resident's metoprolol and amiodarone were documented as being administered, on the above-mentioned dates, and indicated that it should not have been administered, due to his/her HR being below the indicated parameters. She further revealed that if the medications were held multiple times, the nurse should notify the resident's provider and document the notification in a progress note. Additionally, she was unable to provide evidence that the resident's provider was notified of the total opportunities where his/her metoprolol was held due to his/her low HR in December of 2025 and January of 2026.During a surveyor interview on 1/7/2026 at 12:59 PM, with the Director of Nursing Services and the Infection Preventionist, they revealed that CMTs should be obtaining vital signs prior to administering the resident his/her metoprolol or amiodarone and if the medication is held, they should inform the nurse. They acknowledged that the resident's metoprolol and amiodarone were documented as being administered on the above-mentioned dates, and indicated that they should not have been administered, as his/her HR was below the indicated parameters. During a surveyor interview on 1/7/2026 at 1:12 PM, with the resident's provider, she revealed that she would expect nursing staff to follow the parameters associated with the resident's metoprolol and amiodarone orders and would expect the medication to be held if his/her vital signs are below the indicated parameters. She further revealed that she would expect nursing to notify her if the resident's metoprolol or amiodarone were held. Additionally, she revealed that she was unaware the resident's metoprolol was being held often due to his/her low HR and would expect to be notified, indicating that if she had been made aware, she would have considered a medication adjustment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on clinical record review, surveyor observation, and staff interview, the facility failed to maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections relative to not following transmission-based precautions for 1 of 2 residents reviewed, Resident ID #4.Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health (RIDOH) on 1/5/2026 alleged that the facility had residents with norovirus (a highly contagious virus that causes gastroenteritis, leading to symptoms like vomiting, diarrhea, and stomach cramps) since last week.Review of an untitled and undated facility policy, states in part, .Transmission based precautions are the second tier of basic infection control and are used in addition to Standard-based precautions for patient who may be infected or colonized with certain infectious agents for which additional precautions are needed.Wear PPE [personal protective equipment] appropriate to the transmission mode or the organism.Types of Transmission Based Precautions: Contact transmission is infection spread through direct contact with an infectious person (e.g., touching during a handshake) or with an article or surface that has become contaminated.Infection Control Measures for Contact Precautions include.Standard precautions infection control measures.PPE, including gloves and gown for all interactions that may involve contact with resident or resident's environment.Review of a facility policy titled, Norovirus Prevention and Control dated December 2023, states in part, .Avoid exposure to vomitus or diarrhea. Place residents on Contact Precautions in a single occupancy room, if possible, when symptoms are consistent with norovirus gastroenteritis .When residents with norovirus gastroenteritis cannot be accommodated in a single occupancy rooms, efforts will be made to separate them from asymptomatic residents.During outbreaks, residents with norovirus gastroenteritis will be placed on Contact Precautions for a minimum of 48 hours after the resolution of symptoms.Longer periods of isolation or cohorting for medically complex residents may be considered based on clinical judgement.Record review revealed Resident ID #4 was readmitted to the facility in November of 2025 with a diagnosis including, but not limited to, dementia.During a surveyor interview on 1/7/2026 at 8:51 AM, with the Administrator, she revealed that the facility was currently experiencing a norovirus outbreak and revealed that those residents experiencing symptoms were placed on contact precautions.During a surveyor interview on 1/7/2026 at 9:03 AM, with the Infection Preventionist, she revealed that the facility admitted a resident on 12/31/2025, who was positive for norovirus, and revealed that by the 3:00 PM to 11:00 PM shift on 1/1/2026, a few residents were experiencing gastrointestinal (GI) symptoms, consistent with norovirus, including vomiting and loose stools (diarrhea). She revealed that all residents who were experiencing GI symptoms were placed on contact precautions, as directed by the RIDOH and the Medical Director. Further, she revealed she had created a line list of residents affected.Review of the facility provided line list revealed that as of 1/6/2026, 21 residents have been identified as experiencing GI symptoms, such as nausea, vomiting, and diarrhea.During a facility tour on 1/7/2026 at 11:43 AM, 10 resident rooms were noted to be on contact precautions, and 2 resident rooms were noted to be on contact/droplet precautions (requires the use of gown, gloves, a face shield, and a mask upon room entry). During a surveyor observation on 1/7/2026 at 11:44 AM, of Resident ID #4's room, revealed signage posted outside the door to utilize contact precautions when entering the resident's room, which includes performing hand hygiene before entering and when exiting the room and wearing a gown and gloves before room entry.Record review revealed a physician's order dated 1/3/2026 for contact precautions relative to GI symptoms.During a surveyor observation on 1/7/2026 at 11:45 AM, revealed Nursing Assistant, Staff C, enter the resident's room without wearing a gown or gloves. Staff C, then exited the resident's room, failed to perform hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene, walked down the hallway and entered a clean linen storage room. Staff C then exited the clean linen storage room with clean linens in her hand, walked back to the resident's room, and re-entered without wearing a gown or gloves. During a surveyor interview on 1/7/2026 at 11:47 AM, following the above observation, with Staff C, she revealed that the resident was on contact precautions due to the norovirus. She acknowledged the contact precautions signage posted outside the resident's room, acknowledged that she did not wear the appropriate PPE, and did not perform hand hygiene after exiting the resident's room. Further, she acknowledged that she should have been wearing the appropriate PPE and performed hand hygiene, when entering and exiting the resident's room, per the signage posted outside of the room.During a surveyor interview on 1/7/2026 at 11:53 AM, with the Infection Preventionist, she revealed that she would expect staff to follow the signage posted outside the resident's room and would expect staff to wear the appropriate PPE, including a gown and gloves when entering the resident's room.During a surveyor interview on 1/7/2026 at 11:58 AM, with the Administrator, she revealed that she would expect staff to follow the contact precaution signage posted outside of the resident's room.