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	02/19/2026

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that residents are free of any significant medication errors for 1 of 3 residents reviewed for end-of-life comfort medications, Resident ID #1. Findings are as follows:Review of community reported complaint submitted to the Rhode Island Department of Health on [DATE] alleges in part, on [DATE] the facility had multiple problems with the nurse who was working the 11:00 PM to 7:00 AM shift. It revealed that during the shift there was a resident actively passing away and the nurse did not give him/her any comfort medications.Record review revealed the resident was admitted to the facility in January of 2026 with diagnoses including, but not limited to, Alzheimer's disease, hypertension, and atherosclerotic heart disease of the native coronary artery (a buildup of plaque in the coronary arteries that cause narrowing, affecting blood flow).Record review of a Hospice Recommendation form dated [DATE] revealed recommendations to include:-To schedule Morphine concentrate (a medication prescribed to relieve severe pain, often prescribed for comfort during end of life) 5 milligrams (mg), every 2 hours-To schedule Ativan concentrate (Lorazepam Intensol- a medication prescribed to relieve anxiety, often prescribed for end-of-life agitation) 0.5 mg, every 2 hours-To change as needed Morphine concentrate to 5 mg every hour as needed-To change as needed Ativan concentrate to 0.5 mg every hour as neededDuring a surveyor interview on [DATE] at 1:14 PM with the Hospice Registered Nurse (RN), she revealed that she was called in for an end-of-life visit for the resident who was declining on [DATE] at 4:00 PM- 5:00 PM. She made the above recommendations during this visit. She revealed that the resident was having increased pain and agitation, so she recommended to increase the frequency of Morphine and Ativan to every 2 hours routinely with as needed orders for breakthrough pain or agitation every hour. She stated when she conducted her assessment of the resident any movement caused him/her to groan and grimace. She further indicated that when asked by the family how long the resident had left to live, she didn't feel it would be long.Record review of the resident's Medication Administration Record (MAR) for January of 2026 revealed the following active orders at the time of the resident's death on [DATE] at 6:17 AM:-Lorazepam intensol 2 mg/milliliter (ml) give 0.25 ml three times daily- Lorazepam intensol 2 mg/ml give 0.25 ml every 2 hours as need for restlessness- Morphine sulfate 20 mg/ml give 0.25 ml every 2 hours as needed for pain greater than 4Further review of the [DATE] MAR failed to reveal evidence that the hospice recommendations to change the resident's end-of-life comfort medications were implemented.During a surveyor interview on [DATE] at 12:30 PM with Registered Nurse, Staff A, she revealed that the resident was having increased pain and agitation, so hospice was called, and a nurse was sent on the evening of [DATE]. She further indicated that she had texted the new hospice recommendations to the resident's physician.Surveyor observation of the text message dated [DATE] at 5:00 PM revealed, Resident ID #1 had new hospice recommendations for scheduled and as needed every 1-hour Ativan and Morphine. It further stated [s/he] is dying. The physician's text message in response revealed ok.During a subsequent interview (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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on [DATE] at 12:45 PM with Staff A, she failed to provide evidence that the orders for Morphine and Ativan to be administered every two hours routinely were implemented for the resident. Additionally, she failed to provide evidence the as needed orders for Morphine and Ativan were ever changed to reflect that they could be administered every hour.During a surveyor interview on [DATE] at 1:27 PM with the resident's physician, she indicated that the nurse should have implemented the hospice recommendations to increase the frequency for the resident's end-of-life medications after she approved them.Review of the MAR for [DATE] revealed the last administered dose of the Ativan was at 10:00 PM on [DATE], approximately 8 hours prior to the resident's death.Further review of the MAR for [DATE] revealed the last administered dose of the Morphine was at 2:13 PM on [DATE], approximately 16 hours prior to the resident's death.During a surveyor interview on [DATE] at approximately 1:00 PM with the Director of Nursing Services, she acknowledged that the resident did not receive his/her Ativan and Morphine, as ordered, for end-of-life comfort.Cross reference F 849

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on clinical record review and staff interview, the facility failed to ensure that hospice services meet professional standards and principles that apply to individuals providing services in the facility for 1 of 3 residents reviewed who is receiving hospice care, Resident ID #1.Findings are as follows:Record review of a facility policy titled, Coordination of Hospice Services Policy revealed in part, .The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility.The facility will monitor for medications and medical supplies to ensure they are provided by hospice as indicated in the plan of care for palliation and management of the terminal illness.all residents receiving hospice will continue to receive the same facility services as residents who have not elected hospice.medication administration.and ongoing monitoring of resident conditions.Record review revealed the resident was admitted to the facility in January of 2026 with diagnoses including, but not limited to, Alzheimer's disease, hypertension, and atherosclerotic heart disease of the native coronary artery (a buildup of plaque in the coronary arteries that cause narrowing, affecting blood flow).Record review revealed that the resident was receiving hospice services during his/her time at the facility.Record review of a Hospice Recommendation form dated 1/30/2026 revealed the patient was seen for an end-of-life visit. The resident was experiencing periods of apnea (a condition where breathing temporarily stops during sleep) along with a racing pulse and increasing pain. Recommendations were made during the visit which included the following:-To schedule Morphine concentrate (a medication prescribed to relieve severe pain, often prescribed for comfort during end of life) 5 milligrams (mg), every 2 hours-To schedule Ativan concentrate (Lorazepam Intensol- a medication prescribed to relieve anxiety, often prescribed for end-of-life agitation) 0.5mg, every 2 hours-To change as needed Morphine concentrate to 5 mg every hour as needed-To change as needed Ativan concentrate to 0.5 mg every hour as neededDuring a surveyor interview on 2/19/2026 at 1:14 PM with the Hospice Registered Nurse (RN), she revealed that she was called in for an end-of-life visit for the resident who was declining on 1/30/2026 at 4:00 PM- 5:00 PM. She made the above recommendations during this visit. She revealed that the resident was having increased pain and agitation, so she recommended to increase the frequency of Morphine and Ativan to every 2 hours routinely with as needed orders for breakthrough pain or agitation every hour. She stated when she did her assessment of the resident any movement caused him/her to groan and grimace. She further indicated that when asked by the family how long the resident had left to live, she didn't feel it would be long.Record review of the resident's progress notes revealed the following:-On 1/30/2026 at 11:55 AM- Spoke with hospice about resident's [respiratory rate] 30 [Normal respiratory rate is between 12- 20 breaths per minute] and restlessness and received recommendation to increase frequency from Q4hr [every 4 hours] prn [as needed] to Q2 hours prn. [Physician name] informed and approved.-On 1/31/2026 at 6:36 AM- Resident passed away at 0617. [Hospice name] called.Further review of the progress notes failed to reveal any nurses' notes assessing the resident's condition between 1/30/2026 at 11:55 AM and 1/31/2026 at 6:17 AM when it was noted that the resident had passed away, per the facility policy.Record review of the resident's clinical record including the progress notes, physician's orders, and Medication Administration Record (MAR) for January 2026, failed to reveal evidence that the hospice recommendations that were made during the end-of-life visit at 4:00 PM- 5:00 PM on 1/30/2026 were communicated to the resident's physician or implemented for end-of-life comfort.Review of the MAR for January 2026 revealed the last documented dose of the Ativan administered was at 10:00 PM on 1/30/2026, approximately 8 hours prior to the resident's death.Further review of the MAR for January 2026 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed the last documented dose of the Morphine administered was at 2:13 PM on 1/30/2026, approximately 16 hours prior to the resident's death.During a surveyor interview on 2/19/2026 at approximately 1:00 PM with the Director of Nursing Services, she acknowledged that the resident did not receive his/her Ativan and Morphine per the Hospice recommendations. Additionally, she could not provide evidence the facility nurses provided ongoing monitoring of the resident's condition at end-of-life.Cross reference F 760