

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  04/30/2026
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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and staff interview, the facility failed to keep a resident free from sexual abuse for 1 of 2 residents reviewed, Resident ID #11. Findings are as follows: Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/17/2026 revealed that a staff member reported to the facility that she witnessed a Nursing Assistant (NA) grab Resident ID #11's face and kiss him/her on the lips. Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 4/22/2026 alleged inappropriate interactions between a NA and Resident ID #11. The report included a local police department incident report dated 4/18/2026, indicating that the family of Resident ID #11 intended to pursue charges related to the incident that occurred on 4/17/2026. Review of a policy titled, Abuse, Neglect and Exploitation Policy last revised in March of 2026 states in part, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident .sexual abuse is non-consensual sexual act of any type with a resident. Screening. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. background, reference, and credentials' checks shall be conducted by the facility itself, third party agency or academic institution. The facility will maintain documentation of proof that the screening occurred. Record review revealed Resident ID #11, the victim, was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, dementia. Record review of a Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 0 out of 15, indicating the resident has severely impaired cognition. Record review of the facility's investigation revealed that on 4/17/2026 at approximately 12:00 PM, Certified Medication Technician (CMT) Staff B reported to the Assistant Director of Nursing Services (ADNS) that she observed NA Staff A kiss Resident ID #11 on the lips. The investigation further identified that NA Staff C reported a separate incident in which Staff A was observed kissing Resident ID #11 on the lips on 4/15/2026. During a surveyor interview 4/28/2026 at 8:46 AM with CMT, Staff B, she revealed that on 4/17/2026 she was assisting Resident ID #11 with breakfast. At approximately 9:30 AM, NA Staff A, came into the room and said, I love this [Resident ID #11]. NA Staff A, then made a kissing noise, leaned forward towards the resident and kissed him/her on the lips. She further revealed after the above observation she felt very uncomfortable and discussed the incident with NA, Staff C who reported a similar incident occurred on 4/15/2026. During a surveyor interview on 4/28/2026 at 10:14 AM with Staff C, she revealed that on 4/15/2026 at approximately 10:00 AM she was providing morning care for Resident ID #11. Staff A entered the room and asked Residet ID #11 if s/he remembered her. She then told the resident that she loved him/her and leaned toward the resident making a kissing sound and kissed the resident on the mouth, making full lip to lip contact. When asked whether she reported the incident at the time, Staff C stated that she was fearful of Staff A and only came forward after learning that a similar incident had occurred in the presence of another staff member. During a surveyor interview 4/28/2026 at 11:21 AM with the ADNS she revealed that after the incident was reported the facility started its investigation and suspended Staff A. During a surveyor interview on 4/28/2026 at 1:58 PM with the Administrator and the Director (continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>of Nursing Services, they confirmed the above staff reported that they had witnessed Staff A, kiss Resident ID #11 on 4/15 and 4/17/2026. Additionally, she revealed that the staff member was immediately suspended pending the completion of the investigation and that the staff received additional abuse training. The Administrator was unable to provide evidence that all residents were kept free from abuse. Cross reference F606</p>		

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<p>F 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>Based on record review and staff interview, the facility failed to ensure that prospective employees were screened for a history of abuse, neglect, exploitation, or misappropriation of resident property, as evidenced by 1 of 1 personnel record reviewed for abuse Nursing Assistant (NA), Staff A. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 4/17/2026 revealed that a staff member reported to the facility that she witnessed a NA grab Resident ID #11's face and kiss him/her on the lips.Record review of a community-reported complaint submitted to the Rhode Island Department of Health on 4/22/2026 alleged inappropriate interactions between a nursing assistant and Resident ID #11. The report included a local police department incident report dated 4/18/2026, indicating that the family of Resident ID #11 intended to pursue charges related to the incident that occurred on 4/17/2026.Review of a policy titled, Abuse, Neglect and Exploitation Policy last revised in March of 2026 states in part, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident .sexual abuse is non-consensual sexual act of any type with a resident.Screening.Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property.background, reference, and credentials' checks shall be conducted by the facility itself, third party agency or academic institution.The facility will maintain documentation of proof that the screening occurred.Record review revealed Staff A, was hired on 11/18/2025 as a Nursing Assistant.Review of a Bureau of Criminal Identification (BCI) dated 11/6/2025 states in part, As mandated by both federal and state law, the fingerprints of [Staff A] .were processed to determine if they have a criminal record containing disqualifying information. The results of their fingerprint based Comprehensive Criminal Background check shows that they HAVE DISQUALIFYING INFORMATION as delineated under federal and state law .Surveyor record review following the discovery of the positive BCI revealed that Staff A had an extensive criminal history.During a surveyor interview on 4/28/2026 at 11:46 AM, the Human Resource Director stated that Staff A was hired in November 2025, completed orientation, and is currently working independently as a nursing assistant. She further reported that Staff A disclosed disqualifying information from her BCI, indicating a prior drug-related charge from approximately ten years ago. However, the Human Resource Director stated she did not have any documentation specifying the nature of the disqualifying information and that the information was obtained only through word of mouth.During a surveyor interview on 4/28/2026 at 1:58 PM, the Administrator stated she was aware that Staff A's BCI contained disqualifying information and indicated she exercised her own judgment in proceeding with the hire. She acknowledged that she did not receive documentation detailing the nature of the disqualifying information until it was brought to her attention by the surveyor. She further stated that she had not been at the facility since the allegation of abuse was reported on 4/17/2026 and that a determination regarding Staff A's employment would be made upon completion of the investigation. Cross reference F 600</p>		