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	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Middletown Nursing Center	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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on surveyor observation, clinical record review, and staff interview, the facility failed to ensure residents are treated with respect and dignity relative to 1 of 1 resident observed who was unable to attend meals and activities with his/her fellow peers due to lack of appropriate clothing, Resident ID #3. Findings are as follows:Record review revealed the resident was admitted to the facility in May of 2025 with diagnoses including, but not limited to, anxiety disorder and post-traumatic stress disorder.Record review of a care plan revised on 8/25/2025 indicated that the resident is highly social and willing to participate in a variety of activities, with an intervention to provide reminders of scheduled events. During a surveyor observation on 4/29/2026 at 11:44 AM, the resident was observed in his/her room wearing a hospital gown and seated upright on the bed while other residents were in the dining room for lunch. A subsequent observation of the resident's room revealed only one pair of pants and two T-shirts in the drawer.During a surveyor interview following the above observation, the resident reported that s/he does not attend meals in the dining room due to insufficient clothing appropriate for leaving the room. The resident stated that the facility lost all of his/her clothing, including but not limited to shirts, pants, shorts, and socks, which had been sent to laundry services several months prior and were never returned. The resident further indicated that the Administrator was informed of the issue and stated she would contact the laundry company; however, no follow-up communication occurred, and the missing clothing was neither located nor replaced. Record review failed to reveal evidence of the resident's admission inventory list of his/her belongings during his/her admission in May of 2025.During a surveyor interview on 4/29/2026 at 11:57 AM, the Administrator stated that residents' laundry is handled by an outsourced company and acknowledged that she has contacted the vendor multiple times in the past regarding missing clothing for other residents. She further reported that clothing is sent out without a tracking system or documentation identifying which items belong to which resident. The Administrator also indicated that Resident ID #3 had limited clothing upon admission; however, she was unable to provide documentation of an admission inventory of the resident's belongings. She was unable to provide evidence that the resident was treated with respect and dignity relative to finding appropriate clothing to attend meals and activities in the facility.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review and staff interview, the facility failed to ensure that allegations made by residents are recognized as possible abuse by staff and that all allegations are investigated, for 1 of 2 resident's reviewed for abuse, Resident ID #41. Findings are as follows:Review of a facility policy titled, Abuse, Neglect and Exploitation last revised March of 2026 states in part, .An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.Record review revealed that the resident was admitted to the facility in October of 2025 with diagnoses including, but not limited to, dementia and traumatic brain injury.Review of a progress note dated 3/5/2026 authored by Registered Nurse, Staff D, revealed that a resident reported to her that Resident ID #41 was being inappropriate with another resident.Review of a Psychiatric Evaluation and Consultation dated 3/6/2026 states in part, .Patient is being seen per facility request due to increased sexually inappropriate behaviors towards other residents.Review of a Psychiatric Evaluation and Consultation dated 3/13/2026 states in part, .Sexual impulses may present an unsafe environment for other patients in facility.During a surveyor interview on 4/27/2026 at 9:39 AM with RN, Staff E, she revealed that Resident ID #41 has been observed touching other resident's shoulders and hands. Per Staff E, Resident ID #41 must be redirected often.During a surveyor interview on 4/27/2026 at 9:58 AM, the Director of Nursing Services (DNS) stated that she was unsure what the documentation regarding Resident ID #41 and the subsequent psychiatric notes referencing sexually inappropriate behavior were referring to.During a surveyor interview on 4/27/2026 at 10:14 AM with RN, Staff D, via the telephone she acknowledged writing a progress note about Resident ID #41 being inappropriate with another resident. Per Staff D, the inappropriate behavior was Resident ID #41 attempting to hug another resident, but s/he did not make contact with the other resident. Additionally, she revealed that she separated both residents and assessed both residents without any concerns identified.During a surveyor interview on 4/27/2026 at 10:30 AM with the Assistant Director of Nursing, she revealed that she was unaware of Resident ID #41 being inappropriate with other residents. Additionally, she acknowledged that the facility did not investigate any allegations regarding Resident ID #41 being sexually inappropriate with other residents.During a surveyor interview on 4/27/2026 at 10:36 AM with the Administrator she acknowledged that an investigation had not been completed to determine what sexually inappropriate behavior had occurred with Resident ID #41. Additionally, she was unable to provide evidence that the staff identified allegations made by residents as possible abuse or that all allegations are investigated immediately.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review, surveyor observations, and staff interview, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 1 resident reviewed for following physician orders, Resident ID #32, for 1 of 2 residents reviewed for abuse, Resident ID #11 and for 1 of 2 residents reviewed for wound observations, Resident ID #40. Findings are as follows:1. Record review of an undated policy titled Administering Medications states in part, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by the resident need and benefit .Record review revealed that Resident ID #32 was admitted to the facility in March of 2025 with diagnoses including, but not limited to, dementia and anxiety disorder.Record review of the care plan revised on 4/2/2026 revealed the resident has a communication problem related to a hearing deficit.Record review of a nursing progress note dated 4/22/2026 authored by the Director of Nursing Services (DNS) revealed that the resident complained of difficulty hearing related to the wax build-up in his/her right ear. Record review of a progress note dated 4/22/2026 authored by the Medical Director revealed that the resident was complaining of right ear blockage with wax and ordered Debrox ear drop solution.Review of a physician order dated 4/24/2026 revealed to flush the right ear with warm water two times a day following Debrox usage for 5 days. However, the record did not include a physician's order for the Debrox ear drop solution.Review of the April 2026 Medication Administration Record revealed that the resident's right ear was flushed with warm water on the following dates and times:-4/25 at 8:00 AM and 5:00 PM-4/26 at 8:00 AM and 5:00 PM-4/27 at 8:00 AM and 5:00 PMRecord review revealed that the resident's ears were flushed a total of 6 times.During a surveyor interview on 4/28/2026 at 9:20 AM with the resident, s/he revealed that s/he feels like his/her right ear is still blocked although it had been flushed.During a surveyor interview on 4/28/2026 at 9:42 AM with Registered Nurse (RN), Staff E, she acknowledged that she flushed the resident's right ear with warm water the previous day per the order. Additionally, Staff E, revealed that she was unaware if the resident received the Debrox solution to his/her right ear.During a surveyor interview on 4/28/2026 at 11:12 AM with the DNS she revealed that she received the order for the Debrox ear solution from the Nurse Practitioner due to the resident complaining of ear wax build-up. Additionally, the DNS indicated that the Debrox was ordered to be given twice a day for 5 days and then to flush the right ear. The DNS further acknowledged that she entered the order incorrectly and that the right ear should not be flushed before the debrox solution administration.During a surveyor interview on 4/28/2026 at approximately 2:00 PM with the Nurse Practitioner (NP), she stated that the intended order was for Debrox solution to be administered twice daily for five days prior to ear irrigation, with flushing to be performed one to two times depending on the level of wax buildup. The NP further indicated that she would not have ordered daily ear flushing for a resident. 2. Record review revealed Resident ID #11, was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, dementia.Record review of a community reported complaint submitted to the Rhode Island Department of Health on 4/22/2026 alleges that there were inappropriate interactions between a Nursing Assistant (NA) and Resident ID #11 at the facility. The report included an incident report from the local police department dated 4/18/2026 that indicates that the family for Resident ID #11 wanted to press charges.During a surveyor interview on 4/28/2025 at 1:58 PM with the Administrator and the DNS, they confirmed the staff reported that they had witnessed NA, Staff A, kiss Resident ID #11 on 4/15 and 4/17/2026. Record review failed to reveal evidence that the above noted allegation of abuse was reported to the provider.Review of the comprehensive care plan failed to reveal evidence that it was updated following the allegation of abuse, including the implementation of any interventions to prevent further abuse or address behaviors related to the incident During a surveyor interview on 4/28/2026 at 1:41 PM with the Nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practitioner she was unaware of the incident and would have expected to be notified.During a surveyor interview on 4/28/2026 at 1:51 PM with the Assistant Director of Nursing Services she acknowledged that the provider had not been notified of the allegation of abuse and that the care plan had not been updated.3. Record review revealed that Resident ID #40 was readmitted to the facility in February of 2026 with diagnoses including, but not limited to, peripheral vascular disease and cellulitis of the lower limb.Record review revealed a physician's order to cleanse open areas to the left lower leg with Vashe wound wash (an antimicrobial wound cleanser) and apply xeroform (wound treatment) to wound bed and wrap with kling.During a surveyor observation on 4/27/2026 at 11:51 AM of Registered Nurse, Staff E, performing wound care, she failed to utilize the Vashe wash as ordered to cleanse the wound and instead used normal saline.During a surveyor interview directly following the above observation with Staff E, she acknowledged using normal saline to cleanse the wound and not the vashe wash as ordered.During a surveyor interview on 4/27/2026 at 12:33 PM with the Director of Nursing Services (DNS) she revealed that she would expect the nurse to follow the wound orders as written. Additionally, she was unable to provide evidence that the facility provided care in accordance with professional standards of practice for the above noted residents.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on clinical record review, resident and staff interview, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice for 1 of 2 residents reviewed for pain, Resident ID #17. Findings are as follows:Review of an undated facility policy titled Administering Medications states in part, Medication administration times are determined by resident need and benefit, not staff convenience.Record review revealed that Resident ID #17 was admitted to the facility in April of 2026 with diagnoses including, but not limited to, migraines and chronic pain.Review of a care plan dated 4/20/2026 revealed a goal for the resident to verbalize adequate pain relief with an intervention including, but not limited to, respond immediately to any complaint of pain.Record review revealed a physician's order for Butalbital-APAP-Caffeine Oral Capsule 50-300-40 milligrams (Butalbital-Acetaminophen-Caffeine, Fioricet, a medication used to treat migraines) Administer 1 capsule every 12 hours as needed for migraine pain.During a surveyor observation on 4/29/2026 at 10:30 AM Resident ID #17 was in the hallway complaining of a migraine. The resident was noted to be moaning in pain and holding his/her head.During surveyor observations on 4/29/2026 revealed the following:-10:34 AM Nursing Assistant (NA) Staff F, reported to Licensed Practical Nurse (LPN), Staff G that Resident ID #17 wanted pain medication for a headache.-10:35 AM LPN, Staff G, left the unit.-10:37 AM Resident ID #17 continued to complain of migraine pain. Additionally, s/he reported to RN, Staff H, his/her pain. Staff H told Resident ID #17 that she did not have keys to the medication cart and could not get him/her any pain medication.-10:40 AM Resident ID #17 reported that his/her head hurt bad and s/he wheeled back to his/her room to lay down. Additionally, LPN, Staff G was still off the unit.-10:42 AM Staff G, is back on the unit and did not assess Resident ID #17.-10:55 AM Certified Medication Technician, Staff B reported to LPN Staff G, that Resident ID #17 had a headache and was waiting for pain medication.During a surveyor interview on 4/29/2026 at 11:00 AM with Resident ID #17 s/he revealed that s/he has not been medicated for his/her migraine and reported the pain to be 7 out of 10.During a surveyor interview on 4/29/2026 at 11:07 AM with LPN, Staff G, he revealed that he had not medicated Resident ID #17 for his/her migraine.Record review of the April 2026 Medication Administration Record revealed that Resident ID #17 was medicated with Butalbital-APAP-Caffeine Oral Capsule 50-300-40 MG at 11:10 AM on 4/29/2026 for pain 8 out of 10. The medication was administered 40 minutes after the resident initially complained of pain.During a surveyor interview on 4/29/2026 at 11:13 AM with Staff G he revealed that he was downstairs getting soap at 10:35 AM.During a surveyor interview on 4/29/2026 at 11:41 AM with the Director of Nursing Services she acknowledged that a resident should not wait 40 minutes for pain medication. Additionally, she was unable to provide evidence that the facility provided pain management consistent with professional standards.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 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 2 residents reviewed for antibiotic use, Resident ID #17. Findings are as follows:Review of a facility policy titled, Notification of Changes Policy last revised May 2025 states in part, .The facility must inform the.resident's physician.when there is a change requiring such notification.Record review revealed that Resident ID #17 was admitted to the facility in April of 2026 with diagnoses including, but not limited to, surgical aftercare and complication of surgical and medical care.Record review revealed a physician's order dated 4/3/2026 for Cefadroxil Oral Capsule (antibiotic) 500 milligrams, administer 1 capsule by mouth two times a day for 14 days.Review of the April 2026 Medication Administration Record revealed that the resident did not receive the antibiotic on following dates:-4/3 at 8:00 PM-4/6 at 8:00 PM-4/11 at 8:00 PM-4/12 at 8:00 AM-4/14 at 8:00 PM-4/17 at 8:00 AMRecord review revealed the resident missed a total of 6 doses of his/her antibiotic.Record review failed to reveal evidence that the provider had been made aware of the missed doses of antibiotics.During a surveyor interview on 4/29/2026 at 10:21 AM with Registered Nurse, Staff H, she acknowledged the 6 missed doses of antibiotics for Resident ID #17. Additionally, she revealed that the missed doses should have been reported to the provider. During a surveyor interview on 4/29/2026 at 11:04 AM with the Medical Director, she revealed that she was unaware of the missed 6 doses of antibiotics. Additionally, she revealed that she would have extended the dose of antibiotics so the resident could complete the course if she had known.During a surveyor interview on 4/29/2026 at 11:37 AM with the Director of Nursing Services (DNS) she acknowledged that the resident did not receive 6 doses of his/her antibiotic. The DNS revealed that she would expect the provider to be made aware if a resident misses any dose of an antibiotic. Additionally, she was unable to provide evidence that the resident was kept free from significant medication errors.

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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 of principles that apply to individuals providing services in the facility for 1 of 2 residents reviewed who are receiving hospice services, Resident ID #11. Findings are as follows:Record review revealed that Resident ID #11 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, dementia.Record review revealed the resident started with hospice services in March of 2026.Review of the electronic and paper medical records failed to reveal evidence of the following hospice information, per regulation: - The most recent hospice plan of care- Hospice election form- Physician certification and recertification of the terminal illness- Names and contact information for hospice personnel involved in hospice care- Hospice medication information- Hospice physician and attending physician ordersDuring a surveyor interview on 4/28/2026 at 8:55 AM with Registered Nurse Staff E, she acknowledged that the hospice binder was incomplete. She further stated that she was unsure of the frequency of hospice visits for the resident and did not know the personnel involved in the care of Resident ID #11.During a surveyor interview on 4/28/2026 at 10:44 AM with the Director of Nursing Services, she was unable to provide evidence that the facility had the required hospice information per the regulation.

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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 establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections relative to a clean dressing change for 1 of 2 residents observed for wound care, Resident ID #40. Findings are as follows:Review of a facility policy titled, Wound Treatment Management last revised January 2025 states in part, To promote wound healing of various types of wounds, it is policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders.Record review revealed that Resident ID #40 was readmitted to the facility in February of 2026 with diagnoses including, but not limited to, peripheral vascular disease and cellulitis of lower limb.Record review revealed a physician's order to cleanse open areas to the left lower leg with vashe wound wash (an antimicrobial wound cleanser) and apply xeroform (wound dressing) to wound bed and wrap with kling.During a surveyor observation on 4/27/2026 at 11:51 AM of Registered Nurse, Staff E performing wound care, she failed to establish a clean field. Staff E placed all of her supplies directly on the resident's bed next to his/her left leg where the wound was. Additionally, she removed the dirty dressing from the wound, took off the glove on her left hand and it landed on the wound supplies. Staff E failed to cleanse her hands between removing a dirty glove and applying a clean glove.During a surveyor interview with Staff E directly following the above observations she acknowledged not setting up a clean field and putting the wound supplies on the resident's bed. Per Staff E, she did not want to mess up the resident's bedside table. Additionally, she was unable to explain why she put a dirty glove on top of clean wound supplies and also did not cleanse her hands between taking off dirty gloves and applying clean gloves.During a surveyor interview on 4/27/2026 at 12:33 PM with the Director of Nursing Services (DNS) she revealed she would expect the nurse to set up a clean field for her supplies. Additionally, she revealed that the nurse should have thrown her dirty glove into the trash and cleansed her hands between glove changes.