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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>415034 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>08/27/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Grand Islander Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>333 Green End Avenue<br>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.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41729</b></p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that a resident's Advanced Directive to refuse lifesaving treatment was followed for 1 of 4 residents reviewed, Resident ID #1.</p> <p>Findings are as followings:</p> <p>Review of a facility reported incident received by the Rhode Island Department of Health on [DATE], revealed that a resident passed away in the facility within 24 hours of admission.</p> <p>Record review revealed the resident was readmitted to the facility in August of 2024 with diagnoses including, but not limited to, Atrial Fibrillation (a heart condition that causes irregular and often rapid heartbeat), acute osteomyelitis (an infection in the bone) of the left hand, and diabetes.</p> <p>Record review revealed a document titled, Medical Orders for Life Sustaining Treatment (MOLST) dated [DATE] states in part, .Do Not Attempt Resuscitation [a person who has decided not to allow cardiopulmonary resuscitation (CPR) in an event their breathing or heart stops] .(Allow Natural Death) No defibrillator [a device that sends electric shock to the heart to restore normal rhythm heartbeat if it stopped] should be used on a person who has chosen Do not Resuscitation .</p> <p>Additional record review revealed the above-mentioned MOLST form was signed by a Nurse Practitioner and further indicated that the form was completed with the resident's next of kin.</p> <p>Record review of a progress note dated [DATE] which states in part, .Resident noted to not be breathing, absence of pulse. CPR commenced .nurse placed defibrillator on chest .while gathering paperwork, MOLST obtained from chart and noted to be DNR .CPR was stopped .EMS [Emergency Medical Staff] noted absence of vital signs .</p> <p>During a surveyor interview on [DATE] at 10:23 AM and during a subsequent interview at 11:31 AM, with the Assistant Director of Nursing Services (ADNS), she acknowledged that the resident had a MOLST form which indicated that he/she was a DNR. The ANDS further acknowledged that the staff had performed CPR on the resident when he/she was found unresponsive and should not have.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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