STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415034	A. Building B. Wing	10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grand Islander Center	333 Green End 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure each resident receives adequate supervision to prevent accidents relative to 1 of 3 residents reviewed for falls with injury, Resident ID #1.Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 10/21/2025 indicates that Resident ID #1 was coming out of his/her room with Nursing Assistant (NA; Staff A) when the resident let go of his/her walker and fell backwards, landing on his/her buttocks. When the resident was getting up s/he grabbed the door, which swung open and hit the resident on the head. The resident then went to get up and the staff heard a pop in his/her hip area. The resident complained of hip pain and was transferred to an acute care hospital where s/he was diagnosed with a hip fracture.Record review revealed the resident was readmitted to the facility in October of 2025 with diagnoses including, but not limited to, fracture of the left hip, Alzheimer's disease, repeated falls, and abnormalities of gait and mobility.Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident has a Brief Interview for Mental Status score of 4 out of 15, indicating severe cognitive impairment. Additional review revealed s/he requires supervision and/or touch assistance by staff when ambulating.Record review of a Physical Therapy PT Discharge Summary dated 5/27/2025 through 9/5/2025, states in part, .Patient Progress.[S/he] currently requires S/SBA [supervision/stand-by assist, indicating staff is to be nearby to ensure the patient's safety] with RW [rolling walker] to ambulate 225 ft [feet]. Pt [patient] requires staff assist x1 with RW and S/SBA for ambulation.Review of a progress note dated 10/14/2025 states in part, CNA [nursing assistant] said she was walking resident out to dining room. The resident let go of walker and fell backwards. [S/he] did not hit [his/her] head.Upon assessment resident expressed extreme pain, when [s/he] moved a pop was heard possibly [emanating] from the l [left] hip area. Np [Nurse Practitioner, name redacted] was called. It was decided to send resident to.hospital via 911. Additional review of the resident's records revealed the resident was admitted to the hospital on [DATE] with a left femoral neck fracture and underwent surgery for repair.During a surveyor interview on 10/23/2025 at 1:40 PM with NA, Staff A, she revealed that she has cared for Resident ID #1 several times and knows him/her well. She indicated that on 10/14/2025, she had just finished the resident's care prior to the lunch meal and walked out of the resident's room ahead of him/her while s/he was ambulating with a walker behind her. She indicated that when she turned around, the resident had let go of the walker and fell backwards onto his/her bottom. Additionally, she indicated that by the time she turned around, the resident was too far down to assist. She revealed that immediately following the fall, another NA came to assist her to keep the resident in place until the nurse came over to conduct an assessment of the resident. During that time, the resident tried to get up, and both she and the other NA heard a sound that came from the resident's hip. The resident stated that s/he was in pain. Further, Staff A indicated that she was told that the resident was independent with walking and did not need assistance from staff.During a surveyor interview with the Director of Rehabilitation on 10/23/2025 at 2:43 PM, she revealed that at the time the resident was discharged from physical therapy on 9/5/2025, s/he required supervision/stand-by assistance for ambulation with a rolling walker and was not independent with ambulation. She indicated she would expect staff to stand next to or behind the resident within arm's length ready to assist if needed.During a surveyor interview with the Director of Nursing on 10/24/2025 at 2:34 PM, she revealed that she would expect staff to follow physical therapy recommendations to provide supervision and stand-by assistance as reflected in the resident's MDS and care plan. Additionally, she was unable to provide evidence that the resident was provided with adequate supervision to prevent accidents.