

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2025
NAME OF PROVIDER OR SUPPLIER Grand Islander Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and staff interview, the facility failed to ensure that a resident receives care consistent with professional standards of practice relative to physician's orders for 1 of 2 residents reviewed for wound care, Resident ID #1 Findings are as follows: Review of a facility reported incident submitted to the Rhode Island of Health on 10/1/2025 states in part, that the resident's daughter had made an allegation of neglect against the facility. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states in part, The physician is responsible for directing medical treatment, Nurses are obligated to follow physician's orders unless they believe that the orders are in error or wound harm the clients. Record review revealed the resident was admitted to the facility in August of 2022, with a diagnosis including, but not limited to, basal cell carcinoma (skin cancer). Record review of a progress note dated 8/21/2025 revealed, the resident had a MOHS surgery (a surgical procedure to remove skin cancer) on 8/19/2025. Record review of a Continuity of Care Consultation and Referral Form signed and dated 9/26/2025 by the dermatologist, states in part, .white vinegar and water, 50:50-soaks daily to left temple x 2 weeks. Manuka Honey (a medical honey used for wound healing) twice a day to raw areas on face/neck. do twice a day until healed. Record review of the Treatment Administration Records (TAR) from September 2025 through November 2025 failed to reveal evidence that the above-mentioned physician's orders were implemented. Additional record review failed to reveal evidence the physician at the facility had declined the dermatologist's orders dated 9/26/2025. During a surveyor interview on 11/25/2025 at 12:40 PM with the Administrator, she was unable to provide evidence that the above-mentioned physician's orders had been followed. Additionally, she indicated that she would expect the staff to verify the dermatologist order with the physician at the facility and was unable to provide evidence the order was verified or declined by the physician at 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 415034	If continuation sheet Page 1 of 3

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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)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure a resident receives adequate assistance during transfers to prevent accidents for 1 of 1 resident reviewed, resulting in a left spiral distal tibia fracture (a break in the lower shinbone near the ankle, fracture line that spirals around the bone, often caused by a twisting force) and a [NAME] bilateral distal fibula fracture (a break in the fibula bone of both ankles), Resident ID #2. Findings are as follows:Record review of a facility reported incident submitted to the Rhode Island Department of Health on 9/3/2025 reveals that Resident ID #2 complained of pain in his/her left lower extremity and groin. Nursing assessed the resident and found his/her left lower extremity to be swollen and painful. The resident was ordered to be sent to the emergency room to rule out a deep vein thrombosis (DVT - a blood clot in a vein located deep within the body, commonly found in the leg). The facility was informed that the resident had sustained a left tibia (shin bone) and fibula (smaller of the two lower leg bones between the knee and the ankle) fracture, and would be admitted . The resident had not had a fall, and the cause of the fractures were unknown.Record review revealed the resident was admitted to the facility in November of 2022 with a diagnosis including, but not limited to, Parkinson's disease.Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15, indicating the resident is cognitively intact.Record review of the resident's Lift Transfer Evaluation dated 8/11/2025, revealed the resident required the assist of two people for transfers, with the use of a gait belt (a safety device used to help someone move) and device.Record review of the resident's care plan dated 8/22/2025 revealed that the resident required the assist of two people for transfers, with the use of a gait belt.Record review of a progress note dated 9/2/2025 at 10:35 AM revealed that while assessing the resident and performing a dressing change, the resident complained of pain to his/her left leg and significant edema (swelling caused by excess fluid trapped in your body's tissues) was noted. The resident was assessed by a Nurse Practitioner, and she ordered the resident to be sent to the emergency department to rule out a DVT. Record review of a hospital document dated 9/2/2025, revealed the resident presented to the hospital with a left spiral distal tibia fracture and a [NAME] bilateral distal fibula fracture. Further review revealed the injury was non operable, the resident was to be non-weight bearing and was casted on his/her left lower extremity up to his/her knee.During a surveyor interview on 11/24/2025 at 1:05 PM with the resident, s/he revealed that during a stand pivot transfer (SPT) with Nursing Assistant (NA), Staff A , he attempted to transfer the resident independently, however during the transfer, while the resident was turning to sit, s/he stated that s/he heard a pop and fell backwards and s/he was unable to get back up to complete the transfer. The resident indicated at that time Staff A went to get another NA, Staff B, to assist getting the resident into bed. During a surveyor interview on 11/24/2025 at 1:55 PM with the Director of Rehabilitation, she indicated that the type of fracture sustained by Resident ID #2 would most likely occur during a SPT, when the person does not advance their leg and twists to sit.During a surveyor interview on 11/24/2025 at approximately 3:20 PM with NA, Staff B, he revealed that prior to the resident being non weight bearing and, in a cast, he would transfer the resident independently using a SPT technique. Additionally, he revealed that the resident had always been a SPT and required the assistance of one person. He further revealed that he believed that the resident sustained the fracture during a transfer as the resident would often not lift his/her foot when turning which resulted in the twisting of his/her leg during transitions. Additionally, he revealed that the resident had always been a SPT and required the assistance of one person.During a surveyor phone interview on 11/25/2025 at 12:15 PM with NA, Staff A, he recalled an incident prior to the resident's hospitalization, that when transferring the resident in the bathroom, the resident pulled up to the bar from his/her wheelchair, he assisted the resident to raise from the wheelchair, and s/he suddenly went backwards into the wheelchair. At the time the resident stated the s/he was unable to get out of the wheelchair. Staff A stated he then repositioned the resident in the wheelchair and proceeded to get assistance from Staff B to put the resident in bed to perform care.Record review of documents titled, Daily Staffing Sheets revealed the assignments for Resident ID #2's unit:NA, Staff A, worked the following shifts: 8/31/2025- 5:00 PM -11:00 PM and 11:00 PM -7:00 AM 9/1/2025 -3:00 PM- 11-00 PM and 11:00 PM - 7:00 AM 9/2/2025- 11:00 PM - 7:00 AMNA, Staff B, worked the following shifts: 8/31/2025 - 7:00 AM-3:00 PM and 3:00 PM - 11:00 PM 9/1/2025 - 7:00 AM-3:00 PM and 3:00 PM - 11:00 PM 9/2/2025 - 7:00 AM-3:00 PM and 3:00 PM - 11:00 PMDuring a surveyor interview on 11/25/2025 at 3:39 PM with the Administrator in the presence of the Director of Nursing</p>		