

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 12/05/2025
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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive care, consistent with professional standards of practice, relative to 1 of 1 resident reviewed for abnormal blood work, Resident ID #1. Findings are as follows: 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 would harm the clients. Record review revealed the resident was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, hyperosmolality and hypernatremia (conditions related to abnormally high levels of sodium in the blood stream). Review of a progress note dated 10/25/2025 at 8:20 PM revealed that Resident ID #1's bloodwork was reviewed with the provider who gave several new orders that included, repeat a basic metabolic panel (BMP, a blood test that measures substances in your blood to assess overall health) on Monday (10/27/2025). Review of a physician's order dated 10/25/2025 revealed that the resident was to have his/her repeat BMP drawn on 10/27/2025. Record review failed to reveal evidence that the resident had the repeat BMP on 10/27/2025, as ordered. During a surveyor interview on 10/29/2025 at 12:29 PM with the Director of Nursing Services, in the presence of the Administrator, she revealed that she would expect that the BMP to have been completed on 10/27/2025, as ordered.</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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 resident reviewed for behaviors, resulting in a transfer to an acute care hospital, Resident ID #1. Findings are as follows: Review of a facility reported incident submitted to the Rhode Island Department of Health on 10/28/2025 revealed, Resident ID #1 was displaying disruptive and self-injurious behaviors, and the provider was notified, and ordered to send the resident to the hospital for an evaluation. Additionally, while awaiting transfer, the resident was found in his/her room with a plastic bag over his/her head. Further, staff immediately removed the bag and then s/he was placed on a 1:1 supervision until s/he was transferred to the hospital. Review of a facility job description for a Social Services position revised 11/17/2020 states in part, Advocacy. Works with patients/residents, families, and significant others to provide support and information for taking a more proactive role in self-advocacy to improve the quality of life/care for individual patients/residents. Record review revealed the resident was admitted to the facility in April of 2024 with a diagnosis including, but not limited to, psychotic disorder with hallucinations due to a known physiological condition. Review of a progress note dated 10/28/2025 at 10:57 AM revealed, the resident was becoming extremely behavioral, and the provider was contacted. Additionally, the resident was found in his/her room with a plastic bag over his/her head. Further, the bag was removed, s/he was placed on 1:1 supervision, and transported to the hospital for a psychiatric evaluation. Review of the facility acute care transfer form document that was sent with the resident to the hospital revealed that s/he was recently issued a 30-day notice by the facility related to billing. Review of a document titled, emergency room VISIT NOTES dated 10/28/2025, states in part, 'Per RN [Registered Nurse] at NF [Nursing Facility] '[S/he] needs a lot of help and won't let us help [him/her]. [S/he] got a thirty day notice the other day for not paying, and I know that upset [him/her].' During a surveyor interview on 10/29/2025 at 12:10 PM with RN, Staff A, she revealed that she was unsure if Social Services had visited with the resident following the issuance of his/her 30-day notice and would have expected them to. She further revealed that the 30-day notice could have prompted his/her increased behaviors that resulted in a hospital transfer on 10/28/2025. During a surveyor interview on 10/29/2025 at 12:19 PM, with the Social Worker, she revealed that the resident and his/her family members were at the facility on Monday, 10/27/2025, the day before the incident occurred, and were having discussions regarding the 30-day notice. She further revealed that she was aware that the resident and his/her family were present at the facility and indicated that she attempted four or five times to visit with the resident, however, did not end up speaking with the resident or his/her family. Record review failed to reveal evidence that the Social Worker spoke to, or attempted to speak to, the resident and/or his/her representative(s) following the issuance of a 30-day notice, until after the surveyor initially inquired. During surveyor interviews on 10/29/2025 at 9:12 AM and 12:26 PM, with the Administrator, she revealed that the facility issued Resident ID #1 a 30-day notice for non-payment on Friday, 10/24/2025. Additionally, she was unable to provide evidence that the facility provided medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for Resident ID #1 after s/he was issued a 30-day notice by the facility. During a surveyor interview on 10/29/2025 at 12:45 PM with the resident's representative, they revealed that they were unaware that the Social Worker was available to speak with on 10/27/2025, nor did the Social Worker make any attempt to speak with them while they were at the facility. They further revealed that they had been requesting to speak with a case manager but the facility offered nothing.</p>		