

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/29/2024
NAME OF PROVIDER OR SUPPLIER Morgan Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Morgan Avenue Johnston, RI 02919	
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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46671</p> <p>Based on surveyor observations, record review, staff, resident and resident representative interviews, it has been determined that the facility failed to treat each resident with respect and dignity, and is cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life relative to assistance with toileting and communication with a resident whose primary language is not the dominant language of the facility, Resident ID #2.</p> <p>Findings are as follows:</p> <p>Review of a facility reported incident submitted to the Rhode Island Department of Health on 3/25/2024 alleges that a Nursing Assistant (NA) punched the resident in his/her leg.</p> <p>Review of an undated facility policy titled, Translation and/or Interpretation Services states in part, .This facility will ensure that individuals who are non-English speaking or have a communication disability will have access to translation and/or interpretation methods .</p> <ol style="list-style-type: none"> 1. The facility will determine a means to communicate with any resident admitted who is non-English speaking . 2. The facility utilizes Interactive Voice Response (IVR) to connect to an interpreter for limited English proficient resident. 3. The facility utilizes Cue Cards (Communication Boards) to assist health professionals and residents who have English language difficulties or communication difficulties to communicate . <p>Record review revealed the resident was admitted to the facility in January of 2024 with diagnoses including, but not limited to, hemiplegia (paralysis on one side of the body) and fracture of the lateral malleolus of the left fibula (ankle fracture).</p> <p>Review of an Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status score of 15 out of 15, indicating intact cognition. Additionally, the MDS revealed that the resident's preferred language is not English, and s/he wants or needs an interpreter to communicate with health care staff.</p> <p>(continued on next page)</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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of a care plan dated 1/3/2024 revealed a focus area indicating that the resident requires the services of an interpreter because English is not his/her primary language. Interventions include, but are not limited to the following:</p> <ul style="list-style-type: none"> - Monitor the resident for signs of withdrawing from attempts to communicate such as symptoms of anger or feelings of frustration. - Provide him/her with a communication board including common words in English and the resident's preferred language to aide in communication for simple daily needs. - Use the Language Line [which includes Video Remote Interpretation Services] as needed to provide adequate communication with the resident. <p>During a surveyor interview on 3/28/2024 at 1:02 PM with the resident and the resident's representative via telephone, the representative translated the following. It was revealed that at some time during the 11:00 PM - 7:00 AM shift on 3/23/2024 into 3/24/2024, the NA (Staff B) assigned to the resident did not assist him/her with transferring from bed to the bathroom as s/he requested and preferred. The resident's representative indicated that the resident wanted to use the bathroom however the NA gave him/her the bedpan instead. Additionally, they indicated that physical therapy had recently cleared the resident for transferring out of bed. Prior to that s/he was not able to bear weight on his/her lower extremity. Staff B was the only staff member present in the room. The resident's representative further revealed that the resident urinated in the bedpan because s/he had no other choice. The NA did not respond to his/her requests to use the bathroom. It was further revealed that at some point the bedpan was filled with urine and the urine had spilled. The resident believes this caused the staff member to become upset and hit him/her on the right leg with a closed fist.</p> <p>During a surveyor observation at the time of the above-mentioned interview, a communication board was observed pinned on the wall near the resident's bed. The communication board contained pictures of common items labeled in the resident's preferred language. Additionally, the resident's bathroom is approximately 10 feet from his/her bed.</p> <p>During a surveyor telephone interview on 3/28/2024 at 3:08 PM, with Staff B, she revealed that she was the NA assigned to provide care to Resident ID #2 during the 11:00 PM - 7:00 AM shift on 3/23/2024 into 3/24/2024. Additionally, Staff B revealed that she entered the resident's room at some time during the shift to provide the resident with care. She further indicated that the resident was speaking in his/her primary language and appeared furious and began throwing things. Staff B indicated that she does not speak the resident's primary language and acknowledged that she did not utilize an interpreter or the communication board and acknowledged she should have. Furthermore, Staff B indicated that she got the nurse to assist her due to the resident's frustrations and indicated that she did not assist the resident to the bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a surveyor telephone interview on 3/29/2024 at 1:22 PM, with Licensed Practical Nurse (LPN) Staff C, she revealed that she was Resident ID #2's assigned nurse on the 11:00 PM -7:00 AM shift on 3/23/2024 into 3/24/2024. Staff C further indicated that Staff B asked her to go into the resident's room towards the end of care because Staff B was having an issue with the him/her. Staff C indicated that the resident pointed to his/her leg and said something in his/her primary language. She further revealed that she does not speak or understand the resident's primary language. Staff C acknowledged that she did not utilize an interpreter, the communication board or the Language Line to communicate with the resident and acknowledged she should have. Staff C further revealed that Staff B does not usually work on the resident's unit and does not believe that she knew the resident goes into the bathroom instead of using the bedpan. Staff C acknowledged that she did not provide Staff B with that information in shift report and acknowledged she should have.</p> <p>During a surveyor interview on 3/29/2024 at 2:43 PM with the Director of Nursing Services (DNS), she revealed that she would expect staff to utilize an interpreter, the communication board, or the Language Line when assisting Resident ID #2 with care to facilitate communication with him/her. Additionally, the DNS was unable to provide evidence that Resident ID #2 was provided with respect and dignity.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46671</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure that all alleged violations involving abuse, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation is made. If the events that cause the allegation involve abuse or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to other officials (Rhode Island Department of Health;RIDOH), in accordance with State law, for 1 of 1 resident reviewed for an allegation of abuse, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the RIDOH on 3/21/2024, alleges that the facility failed to follow up on an allegation of staff to resident sexual abuse.</p> <p>Record review of a facility policy last revised in September of 2022 titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, states in part, .All reports of resident abuse .are reported to local, state and federal agencies (as required by current regulations) .</p> <p>During a surveyor interview with the complainant on 3/22/2024 at 11:36 AM, s/he revealed that the resident reported an allegation that a male staff member inserted their finger in the resident's rectum during care. Additionally, s/he indicated the facility was made aware of this allegation sometime in January or February of 2024 and indicated the facility failed to follow up on this allegation.</p> <p>Record review revealed the resident was admitted to the facility in December of 2023 with diagnoses including, but not limited to, diabetes, cerebrovascular accident (stroke) and depression.</p> <p>Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition.</p> <p>Surveyor interviews with the resident and his/her family member were attempted, however, unsuccessful throughout the duration of the investigation.</p> <p>During a surveyor interview on 3/22/2024 at 1:00 PM, with the Director of Nursing Services (DNS), she indicated that she was not aware of Resident ID #1's allegation of sexual abuse.</p> <p>During a surveyor telephone interview on 3/22/2024 at 2:10 PM with the Social Services Director (SSD), she revealed that she participated in a telephone care conference held with the resident, the resident's family member, Staff A, and the facility's Wound Nurse in February of 2024. She was unable recall the date. Additionally, the SSD revealed that during the conference, the resident reported that a male staff member inserted their finger in his/her rectum. The SSD further indicated that she immediately reported the allegation to the Administrator.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a surveyor interview with the Administrator on 3/22/2024 at approximately 3:00 PM, in the presence of the DNS and the Regional Director of Clinical Services, he acknowledged that he was made aware of Resident ID #1's allegation of staff to resident sexual abuse on 2/19/2024 after it was reported to staff during a care conference. Furthermore, the Administrator acknowledged that he did not report the allegation to RIDOH or other officials in accordance with State and Federal law and per the facility's policy, until the surveyor questioned him, which was approximately four weeks after he was made aware of the resident's allegation of staff to resident sexual abuse.		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46671</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide evidence that all alleged violations are thoroughly investigated for 1 of 1 resident reviewed for allegations of abuse, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health (RIDOH) on 3/21/2024, alleges that the facility failed to follow up on an allegation of staff to resident sexual abuse.</p> <p>Record review of a facility policy last revised in September of 2022 titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, states in part, .All reports of resident abuse .are .thoroughly investigated by facility management .Within five (5) business days of the incident, the administrator will provide a follow-up investigation report .</p> <p>During a surveyor interview with the complainant on 3/22/2024 at 11:36 AM, s/he revealed that the resident reported an allegation that a male staff member inserted their finger in the resident's rectum during care. Additionally, s/he indicated the facility was made aware of this allegation some time in January or February of 2024 and indicated the facility failed to follow up on this allegation.</p> <p>Record review revealed the resident was admitted to the facility in December of 2023 with diagnoses including, but not limited to, diabetes, cerebrovascular accident (stroke) and depression.</p> <p>Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status score of 13 out of 15, indicating intact cognition.</p> <p>During a surveyor telephone interview on 3/22/2024 at 2:10 PM with the Social Services Director (SSD), she revealed that she participated in a telephone care conference held with the resident, the resident's family member, Staff A, and the facility's Wound Nurse in February of 2024. She was unable recall the specific date. Additionally, the SSD revealed that during the conference, the resident reported that a male staff member inserted their finger in his/her rectum. The SSD further indicated that she immediately reported the allegation to the Administrator.</p> <p>During a surveyor interview with the Administrator on 3/22/2024 at approximately 3:00 PM, in the presence of the DNS and the Regional Director of Clinical Services, he acknowledged that he was made aware of Resident ID #1's allegation of staff to resident sexual abuse on 2/19/2024 after it was reported to staff during a care conference. Furthermore, the Administrator acknowledged that the facility did not conduct a thorough investigation as required.</p>