STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415062	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morgan Health Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50004 Based on record review, staff and resident interview, it has been determined that the facility failed to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical well-being for 2 of 3 residents reviewed relative to follow up appointments, Resident ID #s 1 and 2. Findings are as follows: Review of a community reported complaint submitted to the Rhode Island Department of Health on 4/7/2025 alleges that Resident ID #s 1 and 2 have been trying to get to appointments for his/her hernia (an abnormal exit of tissue or an organ, such as the bowel, through the wall of the cavity in which it normally resides) and a neurologist. Additionally, the report alleges that the facility did not get these appointments and that the residents had to schedule the appointments themselves after waiting almost a year. 1. Record review revealed that Resident ID #1 was admitted to the facility in April of 2023 with diagnoses including, but not limited to, spinal stenosis and diabetes. Review of the progress notes revealed the following: - 9/20/2024: Per the Nurse Practitioner, order for an ultrasound to rule out a hernia. - 9/22/2024: Abdominal ultrasound report sent for review, significant for small right inguinal hernia. Completed for resident's right sided pain and swelling. -10/4/2024: NP [Nurse Practitioner] wants to assure that a GI [Gastrointestinal] surgical consult is being scheduled, we will check w/transport/scheduler. Record review failed to reveal evidence of a GI surgical consult. During a surveyor interview on 4/8/2025 at 10:32 AM with Resident ID #1, s/he revealed that s/he has a hernia and requires a surgical consult. S/he stated, I asked the nurse and transport person several times over the past several months and they did nothing. So, I just called and got one for myself. Additionally, s/he revealed that s/he went to this appointment in March and provided the nurse with the paperwork from the appointment. (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 4/8/2025 at 10:32 AM with the Transport Aide, she revealed that once a consultation is ordered, an appointment slip is filled out and given to her to set up the appointment. She further revealed that she had no documentation for a GI consult for Resident ID #1 and she was unaware that s/he had recently scheduled and went to the appointment in March. During a surveyor interview on 4/8/2025 at 11:09 AM with the outpatient GI provider's receptionist, she revealed that Resident ID #1 had an appointment in March and left with orders for the facility to obtain cardiac clearance for Resident ID #1 to have surgery to repair his/her hernia. During a surveyor interview on 4/8/2025 at 11:42 AM with Licensed Practical Nurse, Staff A, she revealed that she was aware that Resident ID #1 had scheduled their own GI appointment and provided him/her with a Continuity of Care Form. Additionally, she revealed that she was unaware if the form was returned or what the outcome of the appointment was. During a surveyor interview on 4/8/2025 at 11:46 AM with the NP, she revealed that she recently took over his/her care and was unaware that Resident ID #1 went to a GI specialist. Additionally, she was unaware that s/he was waiting on cardiac clearance for surgery. Record review failed to reveal evidence of the March GI appointment or information regarding the outcome of the appointment. During a surveyor interview on 4/8/2025 at 12:15 PM with Resident ID #1's Physician, he revealed that Resident ID #1 recently changed Nurse Practitioners, and it would have been his expectation that the facility would have scheduled and followed up on the order for a GI consult. 2. Record review revealed Resident ID #2 was admitted to the facility in March of 2023 with diagnoses including, but not limited to, diabetes and chronic obstructive pulmonary disease. Review of the progress notes revealed the following: -1/28/2025: lab work ordered by Nurse Practitioner, required for neuro referral. A computed tomography scan (CT scan) and a magnetic resonance imaging (MRI) also required, will schedule. -1/30/2025: Faxed Vitamin B12 result to Neurology, part of referral packet. -1/31/2025: B12 results reviewed with Nurse Practitioner and were advised to fax to Neurology. During a surveyor interview on 4/8/2025 at 10:32 AM with Resident ID #s 1 and 2, they revealed that Resident ID #2 was ordered to have a Neurology consult months ago and when they asked the Transport Aide and nurse, no one could give them any information about the appointment. Additionally, Resident ID #1 stated, After we waited two months, I just called one and made the appointment for April. Record review failed to reveal evidence that Resident ID #2 was receiving care from a neurologist. Record review failed to reveal evidence that the CT/MRI had been scheduled as required. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a surveyor interview on 4/8/2025 at 10:32 AM with the Transport Aide, she indicated that she did receive a referral for a neurology but the nurses do not list where to contact and was unable to complete the appointment. Additionally, she revealed that she had no appointment scheduled for a CT, MRI and there was no follow-up documentation for the neurology referral from January. During a surveyor interview on 4/8/2025 at 11:42 AM with Licensed Practical Nurse, Staff A, she revealed that the appointment was scheduled by the resident's spouse recently. Record review of a nursing progress note dated 3/17/2025, states in part, New Neurohealth appointment 04/25/25 .Res [resident] has own ride provided . During a surveyor interview on 4/8/2025 at 12:15 PM with Resident ID #2's Physician, he revealed that Resident ID #2 recently changed Nurse Practitioners, and it would have been his expectation that the facility would have scheduled and followed up on the order for a neurology referral. During a surveyor interview on 4/8/2025 at approximately 1:00 PM with the Director of Nursing Services in the presence of the Administrator, she was unable to provide evidence that the facility followed up and scheduled the appointments as ordered by the provider.