

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 12/18/2025
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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to promote wound healing and prevent new ulcers from developing for 1 of 2 residents reviewed with a pressure ulcer (a localized injury to the skin and/or underlying skin usually over a bony prominence), Resident ID #1. Findings are as follows: The Rhode Island Department of Health received a community reported complaint on 12/11/2025 alleging that the facility did not have any hygiene supplies for patients and that Resident ID #1 developed bed sores and s/he was re-admitted to the hospital on [DATE] with a pressure ulcer that was not present when s/he was initially discharged from the hospital 11/25/2025. Record review revealed the resident was admitted to the facility in November of 2025 with diagnoses including, but not limited to, laminectomy (back surgery), diabetes mellitus (a chronic condition where the body is unable to regulate blood sugar) and obesity. Record review of an admission skin assessment dated [DATE] revealed the resident had a Stage 2 pressure ulcer (partial thickness loss of skin presenting as a shallow open ulcer with a red-pink wound bed and may also present as an intact or open/ ruptured blister) to his/her coccyx and popped blisters surrounding the coccyx (tailbone). Further review of the assessment failed to reveal evidence of any measurements or a description of the wound. Record review of the physician's orders failed to reveal evidence that a treatment order was implemented for the resident's coccyx wound or popped blisters until 12/2/2025, indicating that the resident's wound was not treated for 6 days. During a surveyor interview on 12/18/2025 at 1:52 PM with the admitting nurse, Licensed Practical Nurse, Staff A, she indicated the resident was admitted with a Stage 2 wound to his/her coccyx and popped blisters surrounding the coccyx. Additionally, she acknowledged that she failed to obtain a treatment order for the resident's wound upon admission. During a surveyor interview on 12/18/2025 at 3:09 PM with the Wound Nurse, Staff B, she revealed that nurses are expected to complete a skin assessment, including measurements and a description of the wound, contact the provider to obtain a treatment order, and implement the treatment order for an identified wound. Additionally, she was unable to provide evidence that the resident received a treatment to his/her coccyx wound from when the wound was first identified on 11/25/2025, until 12/2/2025.</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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