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	04/30/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview, the facility failed to ensure that residents received care and services in accordance with professional standards of practice, resulting in Immediate Jeopardy. Specifically, for 3 of 3 residents reviewed who were prescribed anticoagulant (blood-thinning) medications and experienced falls, the facility failed to implement physician orders for post-fall care. This included failure to conduct timely and frequent neurological monitoring (e.g., every 15 minutes for the first hour) and/or the failure to transfer residents to the hospital as ordered. This deficient practice placed Resident IDs #1, #2, and #3 at risk for serious harm, serious impairment, serious injury or death. Findings are as follows:Review of a community reported complaint submitted to the Rhode Island Department of Health on 4/27/2026 alleged that Resident ID #1 was transferred to the hospital on 4/24/2026 following a fall at the facility on 4/20/2026 with noted head bruising and a last known well date of 4/21/2026. The complaint further alleged that a family member reported prior falls at the facility without hospital evaluation.Record review of a facility policy titled, Falls - Clinical Protocol states in part, .The staff with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma [a type of bleeding that occurs between the brain and its outer protective layer, usually after a head injury, which can press on the brain and be life-threatening] have been ruled out or resolved. A. Record review revealed Resident ID #1 was admitted to the facility in March of 2026 with a diagnosis including, but not limited to, atrial fibrillation (A-fib; is a condition that causes an irregular heartbeat which puts a person at risk of developing blood clots).Record review revealed a physician's order with a start date of 3/18/2026 for Xarelto (a blood thinning medication) 15 milligrams (mg) to be given every evening for A-fib.Record review of a Change in Condition Evaluation form dated 4/5/2026, completed by Licensed Practical Nurse (LPN), Staff A, revealed that at 2:45 AM, the on-call provider was notified of the resident's unwitnessed fall, which resulted in a small laceration to the top of the scalp. The documentation further indicated that the on-call provider recommended hospital evaluation.Review of the provider's progress note dated 4/5/2026 at 3:27 AM revealed the resident underwent a video telehealth evaluation due to falling from bed with findings including a lump on the top of the head with some oozing from the site, left arm pain, and difficulty assessing his/her mental status. Additionally, the note indicates that because the resident hit his/her head, is on blood thinners, and was difficult to assess if s/he has had a further change in his/her mental status. An order was given to transfer the resident to the Emergency Department (ED) for an evaluation.Further record review identified a physician's order document scanned into the Electronic Medical Record (EMR), dated 4/5/2026 at 1:30 AM, directing that Resident ID #1 be transferred to the ED.Further record review failed to reveal evidence that the order was implemented.Additional record review revealed a physician's order dated 4/5/2026 for the resident's vital signs and neuro checks to be completed every shift for 72 hours following a fall.Further record review revealed that the order was not completed as ordered on 4/7/2026 during the 7:00 AM to 3:00 PM shift.During a surveyor interview on 4/29/2026 at 8:53 AM, with LPN, Staff A, she acknowledged that she was the nurse assigned to care for Resident ID #1 during the 11:00 PM to 7:00 AM shift on 4/4/2026 into 4/5/2026. Additionally, she stated that she notified the on-call (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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NAME OF PROVIDER OR SUPPLIER Morgan Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 80 Morgan Avenue Johnston, RI 02919	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	provider of the resident's fall with a head strike and that s/he was prescribed a blood thinning medication. Staff A further revealed that the provider ordered the resident to be transferred to the ED for an evaluation and indicated that she did not send him/her to the ED for an evaluation, because the facility administrative staff have instructed nurses many times to call a supervisor prior to sending a resident out to the hospital. She further revealed that she was not able to speak with the nursing supervisor, Registered Nurse (RN)/Staff Development Coordinator, Staff B, during the 11:00 PM to 7:00 AM shift on 4/5/2026, as she unable to be located in the facility so she sent her a text message indicating the provider's orders, to which Staff B never responded to before the end of her shift. Staff A acknowledged that she did not send Resident ID #1 to the hospital, as ordered by the provider.B. Record review revealed that Resident ID #2 was readmitted to the facility in August of 2025 with a diagnosis including, but not limited to, A-fib.Record review revealed a physician's order dated 8/8/2025 for Xarelto 15 mg to be given every evening for A-fib.Further record review revealed a progress note dated 3/22/2026 at 10:57 AM, authored by RN, Staff C, which indicates that the resident receives blood thinning medication and had an unwitnessed fall at approximately 10:50 AM. Additionally, the note indicates that an on-call provider was notified and gave an order for neurological assessments to be completed every shift for 72 hours.Review of the on-call provider's progress note dated 3/22/2026 at 1:30 PM, indicates the resident had an unwitnessed fall with injury, denies hitting his/her head, and receives blood thinning medication. The note further indicates that s/he refused to be transferred to the hospital and orders were given for neuro checks to be completed every 15 minutes for one hour, every 30 minutes for one hour, hourly for four hours, then every four hours for an additional 24 hours.Additional record review revealed a physician's order scanned into the EMR dated 3/22/2026 for the neuro checks to be completed every 15 minutes for one hour, every 30 minutes for one hour, hourly for four hours, then every four hours for an additional 24 hours.Further record review failed to reveal evidence that the neuro checks were completed as ordered as the neuro checks were only completed once a shift for 72 hours. During a surveyor telephone interview on 4/29/2026 at 12:44 PM, with Staff C, she stated that she could not remember why she did not transcribe and complete the neuro checks as the on-call provider ordered.Record review revealed Resident ID #3 was admitted to the facility in November of 2023 with a diagnosis including, but not limited to, A-fib.Record review revealed a physician's order dated 12/24/2024, for Apixaban (a blood thinning medication) 2.5 mg every 12 hours for anticoagulant use.Record review revealed a progress note dated 2/15/2026 at 6:19 AM, authored by LPN, Staff D, which revealed that the resident was found on the floor after attempting to walk independently. The note further indicated that the on-call provider was notified with orders given for neuro checks.Review of the on-call provider's progress note dated 2/15/2026 at 5:19 AM, indicates the resident had a non-injury fall and receives blood thinning medication. The note further indicates that an order was given for neuro checks to be completed every 15 minutes for one hour, every 30 minutes for one hour, hourly for four hours, and every four hours for an additional 24 hours.Additional record review revealed a physician's order scanned into the EMR dated 2/15/2026 to complete neuro checks every 15 minutes for one hour, every 30 minutes for one hour, hourly for four hours, then every four hours for an additional 24 hours.Further record review failed to reveal evidence that the neuro checks were completed as ordered as the neuro checks were only completed once a shift for 72 hours. A surveyor interview with the Staff D, was attempted but unsuccessful, as she did not return the surveyor's call.During a surveyor interview on 4/28/2026 at 1:11 PM, with the Medical Director, he stated that he would have expected Resident ID #1 to be transferred to the ED as ordered. Additionally, he stated that the facility should not override a provider's order.During surveyor interviews with the Director of Nursing Services on 4/28/2026 at approximately 3:00 PM and 4/30/2026 at 10:56 AM, she acknowledged that Resident ID #1 was not transferred to the hospital as ordered, and that the order for monitoring vitals and conducting neurological assessments every shift for 72 hours after the fall was not completed as ordered on 4/7/2026 during the 7:00 AM to 3:00 PM shift. She indicated that her expectation is for the nurses to follow physician's orders. Additionally, (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	she acknowledged that Resident ID #s 2 and 3, sustained falls, were both prescribed blood thinning medications and the facility staff were provided with orders to monitor their neurological signs frequently and were instead provided with neurological monitoring once a shift for 72 hours. The facility's failure to implement physician orders for post-fall care including timely transfer to the ED and frequent neurological monitoring for residents receiving anticoagulant therapy represents a serious and systemic breakdown in care. For Resident ID #1, the failure to carry out a direct physician order for hospital transfer following a head injury while on a blood thinner significantly delayed necessary medical evaluation. For Resident IDs #2 and #3, the failure to perform neurological assessments at the ordered frequency following falls resulted in inadequate monitoring for potential delayed complications, including intracranial bleeding. The facility's actions placed residents at risk for serious harm, serious impairment, serious injury, or death. Cross reference: State tag 1.16.6.C