RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01500	A. BUILDING: _____ B. WING _____	C 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIGHTHOUSE AT LINCOLN	425 ALBION ROAD LINCOLN, RI 02865

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 003	Initial Comments A complaint investigation, ACTS reference numbers 104078, 104042, and 104010, was conducted at this residence on 07/15/2026 to determine compliance with state laws and regulations. Deficiencies were identified.	S 003	Received JUL 27 2026 Facilities Regulation	
S 390	Residency Requirements 2.4.17.D Resident Assessment/Service Plans 2.4.17 (D) Resident Assessments and Service Plans D. The assessment shall be reviewed and at intervals not to exceed twelve (12) months and each time a resident's condition changes significantly. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to document in the comprehensive assessment each time a resident's condition changed significantly relative to ambulation for 1 of 7 residents reviewed, Resident ID #1. Findings are as follows: The Rhode Island Department of Health received a report on 07/08/2026 that revealed on 07/07/2026 Resident ID #1 had an unwitnessed fall when Nursing Assistant (NA), Staff A, was present, but had left the resident in the hallway while she retrieved gloves from the nursing station. Review of the Assisted Living Residence 5-day	S 390	1. Resident ID # 1's comprehensive assessment (Appendix C) was updated to reflect stand by assist. 2. All resident charts were reviewed by the Resident Care Director and the Executive Director to verify the comprehensive assessment (Appendix C), service plan and Yardi reflect the same information pertaining to each residents' status. 3. The RCD and ED will review all resident change in status to verify it is reflected on the comprehensive assessment (Appendix C), service plan and Yardi. The ED will not sign off on any changes until all areas have been verified. 4. The Reflections Director will review 10% of the change in status in morning meeting and review results at the Quality Assurance meeting for the next 6 months.	7/20/2026

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE ED — (X6) DATE 7/27/26

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S 390	Continued From page 1 report revealed Resident ID #1 was found lying on the floor on his/her side with the walker underneath him/her. The resident sustained a large skin tear to his/her right hand. The resident was bleeding from his/her face and nose, and his/her bilateral eyes were blackened. Resident ID #1 passed away on 07/10/2026. Record review revealed Resident ID #1 moved into the residence in February of 2022 with a diagnosis including, but not limited to, dementia. Record review of the comprehensive assessment, dated 02/03/2026, revealed "Section Two-Activities of Daily Living" states in part, "...Ambulation...cueing and reminders to use the walker..." Review of the service plan, dated 02/03/2026, revealed for mobility the resident utilizes a rolling walker and requires a stand-by assist and occasional hands on for balance and safety. Review of the "Hospice Care Coordination Note(s)" revealed the following entries: - 06/16/2026, "...requires assist with ADL's (activities of daily living) and standby assist to ambulate with walker...is a high fall risk r/t (relative to) unsteadiness and intermittent episodes of weakness..." - 06/24/2026, "...continues to ambulate with walker and 1 assist...is a high fall risk d/t (due to) weakness and poor safety awareness..." During a surveyor interview with the Resident Care Director (RCD) on 7/15/2026 at approximately 2:45 PM, she could not provide evidence that the assessment was updated to	S 390		

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S 390	Continued From page 2 document that the resident requires a standby assist for ambulation.	S 390		
S 405	Residency Requirements 2.4.17.G.1. Resident Assessment/Service Plans 2.4.17 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident ' s requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interviews, it has been determined the residence failed to have	S 405	1. Resident ID # 1's comprehensive assessment (Appendix C) was updated to reflect stand by assist. 2. All resident charts were reviewed by the Resident Care Director and the Executive Director to verify the comprehensive assessment (Appendix C) service plan and Yardi reflect the same information pertaining to each residents' status. 3. The RCD and ED will review all resident change in status to verify it is reflected on the comprehensive assessment (Appendix C), service plan and Yardi. The ED will not sign off on any changes until all areas have been verified. 4. The Reflections Director will review 10% of the change in status in morning meeting and review results at the Quality Assurance meeting for the next 6 months.	7/20/2026

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S 405	Continued From page 3 the party responsible for arranging and/or providing the service, relative to the need of assistance for mobility, for 1 of 7 residents reviewed, Resident ID #1. Findings are as follows: The Rhode Island Department of Health received a report on 07/08/2026 that revealed on 07/07/2026 Resident ID #1 had an unwitnessed fall when Nursing Assistant (NA), Staff A, was present, but had left the resident in the hallway while she retrieved gloves from the nursing station. Review of the Assisted Living Residence 5-day report revealed Resident ID #1 was found lying on the floor on his/her side with the walker underneath him/her. The resident sustained a large skin tear to his/her right hand. The resident was bleeding from his/her face and nose, and his/her bilateral eyes were blackened. Resident ID #1 passed away on 07/10/2026. Record review revealed Resident ID #1 moved into the residence in February of 2022 with a diagnosis including, but notlimited to, dementia. Record review of the comprehensive assessment, dated 02/03/2026, revealed the resident had falls on: 02/05/2026, 02/23/2026, 03/19/2026, 06/09/2026, 06/28/2026, and 07/03/2026. Review of the service plan, dated 02/03/2026, revealed for mobility the resident utilizes a rolling walker and requires a stand-by assist and occasional hands on for balance and safety. Review of the "Hospice Care Coordination	S 405		

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S 405	Continued From page 4 Note(s)" revealed the following entries: - 06/16/2026, "...requires assist with ADL's (activities of daily living) and standby assist to ambulate with walker...is a high fall risk r/t (relative to) unsteadiness and intermittent episodes of weakness..." - 06/24/2026, "...continues to ambulate with walker and 1 assist...is a high fall risk d/t (due to) weakness and poor safety awareness..." - 07/03/2026, "...Patient was able to ambulate though nurse reporting gait has been worsening..." - 07/06/2026, "...urinalysis results showing likely UTI (urinary tract infection)..." During a surveyor interview with NA, Staff A on 07/15/2026 at 10:17 AM, she revealed she was assisting another resident when she saw Resident ID #1 walking by him/herself coming from the dining room. She immediately went up to Resident ID #1 and walked with him/her to the nursing station to get gloves. She revealed she was going to take the resident to the bathroom. She further revealed the resident was standing at the open door of the nursing station and she went in to go get gloves, she heard a noise as she was turning around and witnessed the resident on the floor. Additionally, she revealed she doesn't remember how the resident was lying on the floor, she just remembered seeing blood on the resident's arm. This surveyor asked Staff A what a standby assist meant, she replied it meant when you stand next to a resident or right behind them. During a surveyor observation of the nursing	S 405		

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S 405	Continued From page 5 station, during the interview, a bench was revealed immediately outside of the doorway. Staff A acknowledged she did not seat the resident prior to entering the nursing station. During a surveyor interview with the Resident Care Director at approximately 2:40 PM, she could not provide evidence Staff A followed Resident ID #1's service plan by providing him/her standby assistance while the resident was standing at the nursing station.	S 405		
S 900	Special Care License Requirements 2.5.2.G Specific Requirements 2.5.2 (G) Specific Requirements G. The Alzheimer Dementia Special Care Unit/Program shall operate and provide services to all residents of the unit/program in accordance with the prevailing community standard of care for residents with the particular needs and behaviors with dementia. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined the residence failed to operate and provide services to all residents of the Special Care Unit (SCU) in accordance with the prevailing community standard of care relative to admission to a SCU without a physician's diagnosis of dementia for 1 of 7 sample residents reviewed, Resident ID #2. Findings are as follows: Record review of 216-RICR-40-10-2 of the Rhode	S 900	1. Resident ID # 2's diagnosis was Cognitive Impairment and Major Cognitive Disorder. Major Cognitive Disorder was not added to the Comprehensive assessment, service plan or Yardi. MCD is now added to all three locations, as well as dementia. 2. All resident charts were reviewed by the Resident Care Director and the Executive Director to verify each residents had diagnosis of dementia. 3. The RCD and ED will review all new referrals to verify they have a diagnosis of dementia before an assessment is scheduled. 4. The Reflections Director will review 10% of new move-ins in morning meeting and review results at the Quality Assurance meeting for the next 6 months.	7/20/2026

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S 900	Continued From page 6 Island Rules and Regulations for Licensing Assisted Living Residences, states in part, "...Alzheimer Dementia Special Care Unit/Program means a distinct living environment within an assisted living residence that has been physically adapted to accommodate the particular needs and behaviors of those with dementia...The residents of the unit or program have had a standard medical diagnostic evaluation and have been determined to have a diagnosis of Alzheimer's dementia or another dementia..." Record review revealed Resident ID #2 moved into the residence in January of 2026 with diagnoses including, but not limited to: hyperlipidemia, cognitive impairment, and hypertension. Review of the mini-mental state exam, dated 05/12/2026, revealed a score of 23 out of 30, indicating cognitive impairment. Review of the resident's physician's orders failed to reveal that the resident has a diagnosis of dementia. During a surveyor interview with the Resident Care Director on 07/15/2026 at approximately 2:30 PM, she could not provide evidence that the resident met the medical diagnosis criteria required for SCU occupancy.	S 900		