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 02/09/2024

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 An unannounced complaint/incident investigation survey was conducted at this residence. A deficiency was identified.	S 003	RECEIVED MAR 15 2024 FACILITIES REGULATION	
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to provide care and services in accordance with prevailing community standards of care relative to a change in condition of a singular resident reviewed, ID #1. Findings are as follows: According to the American Nurses' Association Standards of Nursing Practice which states in part, "...the collection of data about the health status of the client/patient is systematic and continuous. The data are accessible, communicated, and recorded..." According to Mosby-Year Book, Basic Nursing	S 230	1. Resident ID # 1 has been discharged since 9/17/2023. 2. All associates have been re-educated on the Change of Resident Status, policy, Emergency Response policy, Urgent and Emergency Needs Response policy, and Signs and Symptoms of a Stroke, as well as, the nurses were re-educated on documentation protocol after the State Complaint investigation survey on February 9, 2024. 3. The staff will immediately notify the Resident Care Director or designee regarding a significant change in a residents' status. If it is an emergency, 911 will be called and the Resident Care Director and/or the Executive Director will be notified. The family and physician will be notified of a change in condition. All staff will be re-educated by the RCD on adherence to policies by March 16, 2024.	3/16/2024

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/15/2024

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S 230	Continued From page 1 Theory and Practice, 1995, 3rd Edition, vital signs are to be taken when the clients' general physical condition changes. According to the Declaratory Ruling, issued by the Board of Examiners for Nursing in January 1989, the LPN (Licensed Practical Nurse) is allowed to contribute to the nursing assessment by collecting, reporting, and recording objective data in an accurate and timely manner. Data collection includes observation about the condition or change in the condition of the client and signs and symptoms of deviation from the normal health status. A reported allegation of neglect was received by the Rhode Island Department of Health on 2/2/2024, which states in part, "...family voicing concerns and wrote letter claiming neglect...On 9-16-23 staff reported to the 3-11 nurse that resident was lethargic...[s/he] was sent to the hospital...revealed DX [diagnosis] of Stroke and UTI [urinary tract infection]..." Record review revealed the resident moved into the residence in August of 2022 with a diagnosis of Alzheimer's disease. Record review revealed a nursing progress note written by a LPN, Staff A, dated 9/17/2023 at 11:08 AM which states in part, "Care staff requested this nurse check on resident as [s/he] has difficulty self-feeding this morning...Right sided facial droop noted, resident sent to [acute care hospital] via rescue." Record review of a written statement obtained from Staff A dated 10/9/2023 states in part, "On Sunday September 17th I was passing meds [medication]...when around breakfast [staff]	S 230	4. The Resident Care Director will review all change in condition at stand up and review at the Quality Assurance meeting for the next 6 months.	

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S 230	Continued From page 2 asked if I could look at [resident]. [S/he] reported [s/he] was letting food fall out of [his/her] mouth. When I finished my medications, I went to [unit]. While I was in the wellness office checking [resident] code status...daughter arrived and alerted me of the facial droop..." Review of the letter sent by Resident ID #1's family to the residence and sent to RIDOH by the residence with the allegations of neglect, revealed the daughter arrived at the residence at approximately 10:15 AM on 9/17/2023, and indicted she immediately recognized the signs of stroke her parent was presenting with. Record review failed to reveal evidence the resident's health status was reviewed and recorded in the resident's record when the resident's change in condition was brought to Staff A's attention by the care staff on the morning of 9/17/2023 at breakfast. During a surveyor interview on 2/9/2024 at approximately 9:26 AM, Staff A indicated that she was made aware by the care staff of the resident's change in condition during breakfast time on 9/17/2023 which she stated was "approximately 9:00 AM." Staff A indicated that she did not go directly to the unit when alerted to the resident's change in presentation; she did not go until she had completed her medication administration task on another unit. Staff A could not provide evidence the resident was assessed, and such assessment was recorded in the resident's record. Staff A further acknowledged that she was initially made aware of a in change in the resident's condition by a care staff on 9/16/2023 shortly after lunch time. Staff A further indicated that she told the staff to put the resident in bed and could not provide evidence the	S 230		

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S 230	Continued From page 3 resident was assessed during the 9/16/2023 3-11 shift. Additionally, Staff A acknowledged that this change in condition was not communicated to the appropriate staff, the Director of Wellness, who is a Registered Nurse, or the resident's physician, and recorded in the resident's record. During an interview on 2/9/2024 at approximately 11:30 AM with the Director of Wellness, she could not provide evidence Staff A recorded and communicated the change in the resident's condition when it was initially observed by a care staff on 9/16/2023 during the 7 AM-3 PM shift. Additionally, the Director could not provide evidence Staff A communicated the change in the resident's physician when it was brought to her attention on 9/17/2023.	S 230		