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 05/22/2026

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 references numbers 103171, 103168, 103288, 103442, 103441, 103615, 103697, and 103710, was conducted at this residence on 05/21/2026 through 05/22/2026 to determine compliance with state laws and regulations. A deficiency was identified.	S 003	Received JUN 09 2026 Facilities Regulation	
S 385	Residency Requirements 2.4.17.C Resident Assessment/Service Plans 2.4.17 (C) Resident Assessment and Service Plans C. The Department-approved assessment form, or such other assessment form as approved by the Department, shall be utilized in completing the assessment on each resident who is admitted to the residence. (Approved Department form is available for downloading online at http://health.ri.gov/forms/assessment/AssistedLivingResident.pdf). 1. Assisted living residences not intending to use the Department ' s assessment form shall submit their proposed assessment forms with a cover letter of intent to the Center for Health Facilities Regulation as specified in §2.4.6(A) of this Part. 2. All assessment forms shall report information appropriate to determine compatibility and compliance with the residency criteria, and shall indicate that the resident ' s needs can be met by the assisted living residence within its licensure level, and shall gather information appropriate for the development of an individualized service plan.	S 385	1. Resident ID #1, 2, 3, and 4 Appendix C was corrected to reflect the code status of DNR on 5/22/2026. Resident ID # 1, 2, 3 and 4 had a comprehensive chart review regarding code status in physician's orders, MOLST, service plan, face sheet and the Appendix C. All areas are consistent and documented. 2. All resident charts were reviewed for accuracy with code status to include the physician's orders,MOLST, service plan, face sheet and the Appendix C. 3. All new resident charts will be reviewed by the RCD or designee upon move-in for accuracy and consistency in the physician's orders, MOLST, service plan, face sheet and Appendix C. If a resident/POA elects a new code status, the RCD or designee will immediately update the physician's orders, MOLST, service plan, face sheet and the Appendix C. 4. The RCD or designee will report the findings at the Quality Assurance meeting for the next 6 months.	5/29/2026

Facilities Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: L Dombrowski — TITLE: Executive Director — (X6) DATE: 6/9/26

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 05/22/2026

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 385	Continued From page 1 a. The assessment form shall be designed to demonstrate compliance with the assisted living residence ' s criteria for residency. b. The assessment form shall also be designed to demonstrate that the assisted living residence can meet the resident's needs and preferences. 3. The assessment form shall also be designed to provide information appropriate for the development of an individualized service plan in accordance with § 2.4.16(G)(1) of this Part. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to ensure that comprehensive assessments were completed in their entirety and were accurate, for 4 of 12 residents reviewed, Resident ID #s 1, 2, 3, and 4. Findings are as follows: A. Record review of Resident ID #s 1, 2, and 3's comprehensive assessment revealed the "Code Status" section was not completed. 1) Record review revealed Resident ID #1 moved into the residence in November of 2023 with a diagnosis including, but not limited to, dementia without behavioral disturbance. Record review of the resident's Medical Orders for Life Sustaining Treatment (MOLST), dated 11/23/2023, revealed the resident's code status	S 385	Type text here	

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 05/22/2026

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 385	Continued From page 2 as Do Not Attempt Resuscitation (DNR). Record review revealed an incomplete comprehensive assessment form dated 4/6/2026. 2) Record review revealed Resident ID #2 moved into the residence in September of 2025 with a diagnosis including, but not limited to, mild cognitive impairment. Record review of the resident's MOLST, dated 9/2/2025, revealed the resident's code status as DNR. Record review revealed an incomplete comprehensive assessment form dated 5/15/2026. 3) Record review revealed Resident ID #3 moved into the residence in September of 2023 with a diagnosis including, but not limited to, cognitive decline. Record review of the resident's MOLST, dated 9/14/2023, revealed the resident's code status as DNR. Record review revealed an incomplete comprehensive assessment form dated 3/25/2025. B. Record review revealed an inaccurate assessment form for Resident ID #4. 4) Record review revealed Resident ID #4 moved into the residence in October of 2023 with a diagnosis including, but not limited to, Alzheimer's disease. Record review of the resident's MOLST, dated	S 385	Type text here	

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 05/22/2026

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 385	Continued From page 3 4/3/2024, revealed the resident's code status as DNR. Record review revealed a comprehensive assessment form, dated 3/10/2026, the section for "Code Status" stated the resident is a "Full Code" and has a "MOLST." During a surveyor interview with the Resident Care Director on 5/22/2026 at approximately 2:00 PM, she could not provide evidence the comprehensive assessment form was completed in its entirety including "Code Status" for Resident ID #s 1, 2, and 3. She further could not provide evidence that Resident ID #4's comprehensive assessment form accurately reflected the resident's code status.	S 385	Type text here	