STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415035	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road North Providence, RI 02904

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on surveyor observation, clinical record review, staff and resident interviews, the facility failed to provide the residents with an environment that remains as free of accident hazards as is possible and that each resident receives adequate supervision to prevent accidents for 1 of 1 newly admitted resident who started a fire with a lighter, Resident ID # 1. Findings are as follows:Record review of a community reported complaint report submitted to the Rhode Island Department of Health on 12/29/2025 alleges that a resident had ignited their oxygen tubing while using a lighter. Record review revealed that Resident ID #1 was admitted to the facility in December of 2025 with diagnoses including but not limited to multiple fractures of ribs and a history of falling. Record review of the hospital documentation revealed Resident ID #1 is a smoker. During a surveyor interview with the Regional Director of Clinical Services, the Regional Director of Operations, and the [NAME] President of Operations, on 12/29/2025 at approximately 10:10 AM, they revealed that an incident had occurred just before 4:00 AM in Resident ID # 1's room. Resident ID #1 used a lighter to locate his /her shoes in the dark when s/he accidentally ignited his/her oxygen tubing which caused minor fire damage to the floor and the oxygen concentrator. The Regional Director of Clinical Services indicated that the facility was aware the resident was a smoker at the time of his/her admission. During a surveyor observation on 12/29/2025 at approximately 11:10 AM of Resident ID #1s room revealed a discolored area of the floor that was approximately 9 inches by 12 inches in size. During a surveyor interview with the Regional Director of Operations at the time of the above observation, he revealed that the burnt oxygen tubing and the damaged oxygen concentrator had been removed from the room prior to this survey. Additional surveyor observations on 12/30/2025 at approximately 2:00 PM revealed photos obtained from the local fire department which revealed burnt melted oxygen tubing still in place on the floor and burn marks to the front of the oxygen concentrator. During a surveyor interview with Resident ID #1, on 12/30/2025 at approximately 11:35 AM, s/he revealed that s/he was using his/her personal lighter to find his/her shoes when s/he got the lighter too close to the oxygen tubing and it caught fire. During a surveyor interview with the Regional Director of Clinical Services on 12/30/2025 at approximately 1:35 PM, she was unable to provide evidence that the facility provided the residents with an environment that remains as free of accident hazards as possible.

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