License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **04-01-2026**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
12VAC35-46-300. B. (5) - The records of each employee shall include: 5. Annual performance evaluations;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Employee #1 and Employee #2's personnel record, the provider failed to have evidence of an annual performance evaluation.	PR) 04/22/2026 The corrective action plan regarding annual performance evaluations: The provider did not have documentation of completed annual performance evaluations for Employee #1 and Employee #2. The required evaluations have now been completed and placed in the personnel files. Root Cause: (1) The failure to complete annual performance evaluations resulted from a lack of a structured tracking system for due dates. (2) Additionally, there was insufficient oversight to ensure evaluations were completed timely and filed in employee records. Moving Forward: The provider has completed the required performance evaluations for Employee #1 and Employee #2 and placed them in their personnel records. Moving forward, the Chief Administrative Officer will implement a tracking system to monitor all employee evaluation due dates. The Program Director will ensure evaluations are completed timely and submitted for review. The Chief Administrative Officer will conduct monthly personnel file audits to ensure all required documentation, including performance evaluations, is completed and maintained in compliance. Corrective Action Steps:	4/28/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Personnel File Review: Conduct a full review of all employee files to identify any missing annual performance evaluations. Evaluation Completion: Complete all outstanding performance evaluations and ensure documentation is placed in each employee's file. Tracking System Implementation: Develop and maintain a tracking log for employee evaluation due dates. Ongoing Monitoring: Conduct monthly audits of personnel records to ensure continued compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly personnel file audits using a checklist to ensure all required documentation is present and up to date. OLR) Accepted 04/23/2026	
12VAC35-46-300. B. (7) - The records of each employee shall include: 7. Documentation of educational degrees and of or professional certification or licensure credentials, as applicable;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Employee #1's personnel record, the provider failed to have evidence of the background disclosure statement.	PR) 04/22/2026 The corrective action plan regarding documentation of required personnel records: The provider failed to have evidence of a completed background disclosure statement and documentation of educational credentials in Employee #1's personnel record. The required background disclosure statement and documentation of the employee's degree have	4/28/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			now been obtained and placed in the personnel file. Root Cause: (1) The failure to maintain required documentation, including the background disclosure statement and educational credentials, resulted from incomplete verification of personnel records at the time of hire. (2) Additionally, there was insufficient oversight to ensure all required documents were obtained, verified, and maintained in accordance with regulatory requirements. Moving Forward: The provider has obtained and placed the missing background disclosure statement and degree documentation in Employee #1's personnel record. Moving forward, the Chief Administrative Officer will implement a standardized personnel file checklist to ensure all required documentation, including background disclosure statements and educational credentials, are obtained and verified at the time of hire. The Chief Administrative Officer will conduct monthly personnel file audits to ensure all required documentation is present and maintained in compliance with 12VAC35-46-300. Corrective Action Steps: Personnel File Review: Conduct a full review of all employee personnel files to identify any missing required documentation.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Document Completion: Obtain and place any missing background disclosure statements and educational documentation in employee files. Checklist Implementation: Develop and implement a personnel file checklist to be completed at hire and during routine file reviews. Ongoing Monitoring: Conduct monthly audits of personnel records to ensure continued compliance. Responsible Person(s): Chief Administrative Officer Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly personnel file audits using a standardized checklist to ensure all required documents, including background disclosure statements and educational credentials, are present and maintained in each employee file. OLR) Partially Accepted 04/23/2026The provider"s response appears to be about verification of the employee"s degree and not the background disclosure form. The provider will need to update their response and include their systemic plan of action as it relates to the background disclosure form (completed with then Criminal Background Check). The provider will also need to submit the completed form for review. PR) 04/24/2026 The corrective action plan regarding the documentation of required personnel records:	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The provider failed to have evidence of a completed background disclosure statement in Employee #1's personnel record. The provider verified that the required background disclosure statement was completed and maintained within the confidential (red) folder. The document is being submitted for review. Root Cause: (1) The provider maintained completed background disclosure statements; however, the documentation was not readily identifiable within the personnel record at the time of inspection due to the use of a separate confidential (red) folder and lack of a clear file organization system identifying document location. (2) Additionally, there was insufficient internal verification to ensure all required personnel documentation was easily accessible for review. Moving Forward: The provider verified that the background disclosure statement is maintained within the employee's personnel record. Moving forward, the Chief Administrative Officer will implement a standardized personnel file checklist to ensure all required documentation, including background disclosure statements and criminal background checks, are present, clearly identified, and accessible within each personnel file. The Chief Administrative Officer will conduct monthly personnel file audits to ensure all required documentation is maintained in compliance with 12VAC35-46-300.	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Corrective Action Steps: Personnel File Review: Conduct a full review of all employee personnel files to ensure required documentation is present and properly identified. Document Identification: Ensure all background disclosure statements are clearly identified within the personnel record, including notation of location when maintained in a separate confidential folder. Checklist Implementation: Develop and implement a personnel file checklist to be completed at hire and during routine file reviews, including documentation location tracking. Ongoing Monitoring: Conduct monthly audits of personnel records to ensure continued compliance. Responsible Person(s): Chief Administrative Officer Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly personnel file audits using a standardized checklist to ensure all required documents, including background disclosure statements, are present, current, and properly identified within each employee file. The Program Director will conduct quarterly supervisory reviews of personnel records to ensure ongoing compliance. OLR) Partially Accepted 04/28/2026The provider submitted the incorrect document. The provider will need to submit Employee #1"s disclosure	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			statement (Attachment 3) for review. PR) 04/28/2026 Provider has provided the Disclosure Statement for Employee #1. OLR) Accepted 04/28/2026	
12VAC35-46-750. D. (1) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 1. Resident's progress toward meeting the plan's objectives;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have evidence of a documented quarterly review of each residential's progress 60 days following the initial individualized service plan and within each 90-day period.	PR) 04/22/2026 The corrective action plan regarding quarterly reviews of resident progress toward meeting service plan objectives: The provider failed to have evidence of a documented quarterly review of each resident's progress toward meeting service plan objectives within the required timeframes for Individual #1 and Individual #2. The quarterly reviews have now been scheduled and will be completed and placed in each resident's record. Root Cause: (1) The failure to complete and document quarterly reviews within the required timeframe resulted from a lack of a structured tracking system for due dates. (2) Additionally, there was insufficient oversight to ensure quarterly reviews were completed timely and properly documented in resident records. Moving Forward: The provider has scheduled quarterly ISP review meetings for Individual #1 and Individual #2 to ensure documentation of progress toward service plan objectives is completed and maintained in their records.	4/28/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Moving forward, the Chief Administrative Officer will implement a tracking system to monitor all quarterly ISP review due dates. The Program Director will ensure that quarterly reviews are completed within the required 90-day period and that documentation reflects each resident's progress toward service plan objectives. The Chief Administrative Officer will conduct monthly record reviews to ensure all quarterly ISP documentation is completed timely and maintained in compliance with 12VAC35-46-750. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing or overdue quarterly ISP reviews. Quarterly Review Completion: Schedule and complete all required quarterly ISP reviews for each resident, ensuring documentation reflects progress toward meeting service plan objectives. Tracking System Implementation: Develop and maintain a tracking log for all quarterly ISP due dates. Ongoing Monitoring: Conduct monthly audits of resident records to ensure quarterly ISP reviews are completed within required timeframes. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan:	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all quarterly ISP reviews are completed within required timeframes and that documentation reflects resident progress toward service plan objectives. OLR) Accepted 04/23/2026	
12VAC35-46-750. D. (2) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 2. Family's involvement	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have evidence of a documented quarterly review of each residential's progress 60 days following the initial individualized service plan and within each 90-day period.	PR) 04/22/2026 The corrective action plan regarding quarterly reviews of family involvement: The provider failed to have evidence of a documented quarterly review that included family involvement within the required timeframes for Individual #1 and Individual #2. The quarterly ISP reviews have now been completed and documentation of family involvement has been included and placed in each resident’s record. Root Cause: (1) The failure to document family involvement within the quarterly reviews resulted from incomplete documentation practices during the review process. (2) Additionally, there was insufficient oversight to ensure all required components of the quarterly ISP review were completed and documented. Moving Forward: The provider has completed the quarterly ISP reviews for Individual #1 and Individual #2, and documentation of family involvement has been included in each resident’s record. Moving forward, the Chief Administrative Officer	4/28/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			will implement a tracking system to ensure all required components of the quarterly ISP review, including family involvement, are completed and documented. The Program Director will ensure that all quarterly reviews include documentation of family involvement as required. The Chief Administrative Officer will conduct monthly record reviews to ensure all required components of quarterly ISP reviews are completed and maintained in compliance with 12VAC35-46-750. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing documentation related to family involvement in quarterly ISP reviews. Quarterly Review Completion: Ensure all quarterly ISP reviews include documentation of family involvement. Tracking System Implementation: Develop and maintain a tracking log to ensure all required components of quarterly ISP reviews are completed. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all quarterly ISP reviews include	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			required components, including family involvement. OLR) Accepted 04/23/2026	
12VAC35-46-750. D. (3) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 3. Continuing needs of the resident;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have evidence of a documented quarterly review of each residential's progress 60 days following the initial individualized service plan and within each 90-day period.	PR) 04/22/2026 The corrective action plan regarding quarterly reviews of the continuing needs of the resident: The provider failed to have evidence of a documented quarterly review that included the continuing needs of the resident within the required timeframes for Individual #1 and Individual #2. The quarterly ISP reviews have now been completed and documentation of the residents' continuing needs has been included and placed in each resident's record. Root Cause: (1) The failure to document the continuing needs of the resident within the quarterly reviews resulted from incomplete documentation practices during the review process. (2) Additionally, there was insufficient oversight to ensure all required components of the quarterly ISP review were completed and documented. Moving Forward: The provider has completed the quarterly ISP reviews for Individual #1 and Individual #2, and documentation of the residents' continuing needs has been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure all required components of the quarterly ISP review, including the continuing needs of the resident,	4/28/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			are completed and documented. The Program Director will ensure that all quarterly reviews include documentation of the resident's continuing needs as required. The Chief Administrative Officer will conduct monthly record reviews to ensure all required components of quarterly ISP reviews are completed and maintained in compliance with 12VAC35-46-750. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing documentation related to the continuing needs of the resident in quarterly ISP reviews. Quarterly Review Completion: Ensure all quarterly ISP reviews include documentation of the resident's continuing needs. Tracking System Implementation: Develop and maintain a tracking log to ensure all required components of quarterly ISP reviews are completed. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all quarterly ISP reviews include	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			required components, including the continuing needs of the resident. OLR) Accepted 04/23/2026	
12VAC35-46-750. D. (4) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 4. Resident's progress toward discharge;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have evidence of a documented quarterly review of each residential's progress 60 days following the initial individualized service plan and within each 90-day period.	PR) 04/22/2026 The corrective action plan regarding quarterly reviews of the resident's progress toward discharge: The provider failed to have evidence of a documented quarterly review that included the resident's progress toward discharge within the required timeframes for Individual #1 and Individual #2. The quarterly ISP reviews have now been completed and documentation of each resident's progress toward discharge has been included and placed in each resident's record. Root Cause: (1) The failure to document the resident's progress toward discharge within the quarterly reviews resulted from incomplete documentation practices during the review process. (2) Additionally, there was insufficient oversight to ensure all required components of the quarterly ISP review were completed and documented. Moving Forward: The provider has completed the quarterly ISP reviews for Individual #1 and Individual #2, and documentation of each resident's progress toward discharge has been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure all	4/28/2026

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			required components of the quarterly ISP review, including the resident's progress toward discharge, are completed and documented. The Program Director will ensure that all quarterly reviews include documentation of the resident's progress toward discharge as required. The Chief Administrative Officer will conduct monthly record reviews to ensure all required components of quarterly ISP reviews are completed and maintained in compliance with 12VAC35-46-750. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing documentation related to the resident's progress toward discharge in quarterly ISP reviews. Quarterly Review Completion: Ensure all quarterly ISP reviews include documentation of the resident's progress toward discharge. Tracking System Implementation: Develop and maintain a tracking log to ensure all required components of quarterly ISP reviews are completed. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			monthly record audits using a tracking log to verify that all quarterly ISP reviews include required components, including the resident's progress toward discharge. OLR) Accepted 04/23/2026	
12VAC35-46-750. D. (5) - There shall be a documented quarterly review of each resident's progress 60 days following the initial individualized service plan and within each 90 -day period thereafter that shall report the: 5. Status of discharge planning.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to have evidence of a documented quarterly review of each residential's progress 60 days following the initial individualized service plan and within each 90-day period.	PR) 04/22/2026 The corrective action plan regarding quarterly reviews of the status of discharge planning: The provider failed to have evidence of a documented quarterly review that included the status of discharge planning within the required timeframes for Individual #1 and Individual #2. The quarterly ISP reviews have now been completed and documentation of the status of discharge planning has been included and placed in each resident's record. Root Cause: (1) The failure to document the status of discharge planning within the quarterly reviews resulted from incomplete documentation practices during the review process. (2) Additionally, there was insufficient oversight to ensure all required components of the quarterly ISP review were completed and documented. Moving Forward: The provider has completed the quarterly ISP reviews for Individual #1 and Individual #2, and documentation of the status of discharge planning has been included in each resident's record. Moving forward, the Chief Administrative Officer	4/28/2026

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			will implement a tracking system to ensure all required components of the quarterly ISP review, including the status of discharge planning, are completed and documented. The Program Director will ensure that all quarterly reviews include documentation of the status of discharge planning as required. The Chief Administrative Officer will conduct monthly record reviews to ensure all required components of quarterly ISP reviews are completed and maintained in compliance with 12VAC35-46-750. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing documentation related to the status of discharge planning in quarterly ISP reviews. Quarterly Review Completion: Ensure all quarterly ISP reviews include documentation of the status of discharge planning. Tracking System Implementation: Develop and maintain a tracking log to ensure all required components of quarterly ISP reviews are completed. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan:	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all quarterly ISP reviews include required components, including the status of discharge planning. OLR) Accepted 04/23/2026	
12VAC35-46-900. A. (1) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 1. Identification of positive and problem behavior;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to develop and implement a written behavior support plan.	PR) 04/22/2026 The corrective action plan regarding the development and implementation of behavior support plans identifying positive and problem behaviors: The provider failed to develop and implement a written behavior support plan that included identification of positive and problem behaviors for Individual #1 and Individual #2 within the required timeframe. The behavior support plans have now been completed, and identification of positive and problem behaviors has been included and placed in each resident's record. Root Cause: (1) The failure to develop and implement behavior support plans within the required timeframe resulted from a lack of a structured process to ensure completion of behavior support plans within 30 days of admission. (2) Additionally, there was insufficient oversight to ensure all required components of the behavior support plan were completed and documented. Moving Forward: The provider has completed behavior support plans for Individual #1 and Individual #2, and identification of positive and problem behaviors	4/28/2026

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			has been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure behavior support plans are developed and implemented within 30 days of admission. The Program Director will ensure that all behavior support plans include required components, including identification of positive and problem behaviors. The Chief Administrative Officer will conduct monthly record reviews to ensure all behavior support plans are completed timely and maintained in compliance with 12VAC35-46-900. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing or incomplete behavior support plans. Plan Completion: Develop and implement behavior support plans for each resident, ensuring identification of positive and problem behaviors is included. Tracking System Implementation: Develop and maintain a tracking log to ensure behavior support plans are completed within required timeframes. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan:	

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			The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all behavior support plans are completed within required timeframes and include required components, including identification of positive and problem behaviors. OLR) Accepted 04/23/2026	
12VAC35-46-900. A. (2) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 2. Identification of triggers for behaviors;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to develop and implement a written behavior support plan.	PR) 04/22/2026 The corrective action plan regarding the development and implementation of behavior support plans identifying triggers for behaviors: The provider failed to develop and implement a written behavior support plan that included identification of triggers for behaviors for Individual #1 and Individual #2 within the required timeframe. The behavior support plans have now been completed, and identification of triggers for behaviors has been included and placed in each resident's record. Root Cause: (1) The failure to develop and implement behavior support plans within the required timeframe resulted from a lack of a structured process to ensure completion of behavior support plans within 30 days of admission. (2) Additionally, there was insufficient oversight to ensure all required components of the behavior support plan were completed and documented. Moving Forward: The provider has completed behavior support plans for Individual #1 and Individual #2, and	4/28/2026

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			identification of triggers for behaviors has been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure behavior support plans are developed and implemented within 30 days of admission. The Program Director will ensure that all behavior support plans include required components, including identification of triggers for behaviors. The Chief Administrative Officer will conduct monthly record reviews to ensure all behavior support plans are completed timely and maintained in compliance with 12VAC35-46-900. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing or incomplete behavior support plans. Plan Completion: Develop and implement behavior support plans for each resident, ensuring identification of triggers for behaviors is included. Tracking System Implementation: Develop and maintain a tracking log to ensure behavior support plans are completed within required timeframes. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan:	

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Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all behavior support plans are completed within required timeframes and include required components, including identification of triggers for behaviors. OLR) Accepted 04/23/2026	
12VAC35-46-900. A. (3) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 3. Identification of successful intervention strategies for problem behavior;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to develop and implement a written behavior support plan.	PR) 04/22/2026 The corrective action plan regarding the development and implementation of behavior support plans identifying successful intervention strategies for problem behavior: The provider failed to develop and implement a written behavior support plan that included identification of successful intervention strategies for problem behavior for Individual #1 and Individual #2 within the required timeframe. The behavior support plans have now been completed, and identification of successful intervention strategies for problem behavior has been included and placed in each resident's record. Root Cause: (1) The failure to develop and implement behavior support plans within the required timeframe resulted from a lack of a structured process to ensure completion of behavior support plans within 30 days of admission. (2) Additionally, there was insufficient oversight to ensure all required components of the behavior support plan were completed and documented. Moving Forward:	4/28/2026

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			The provider has completed behavior support plans for Individual #1 and Individual #2, and identification of successful intervention strategies for problem behavior has been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure behavior support plans are developed and implemented within 30 days of admission. The Program Director will ensure that all behavior support plans include required components, including identification of successful intervention strategies for problem behavior. The Chief Administrative Officer will conduct monthly record reviews to ensure all behavior support plans are completed timely and maintained in compliance with 12VAC35-46-900. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing or incomplete behavior support plans. Plan Completion: Develop and implement behavior support plans for each resident, ensuring identification of successful intervention strategies for problem behavior is included. Tracking System Implementation: Develop and maintain a tracking log to ensure behavior support plans are completed within required timeframes. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance.	

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			Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all behavior support plans are completed within required timeframes and include required components, including identification of successful intervention strategies for problem behavior. OLR) Accepted 04/23/2026	
12VAC35-46-900. A. (4) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 4. Techniques for managing anger and anxiety;	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to develop and implement a written behavior support plan.	PR) 04/22/2026 The corrective action plan regarding the development and implementation of behavior support plans identifying techniques for managing anger and anxiety: The provider failed to develop and implement a written behavior support plan that included techniques for managing anger and anxiety for Individual #1 and Individual #2 within the required timeframe. The behavior support plans have now been completed, and techniques for managing anger and anxiety have been included and placed in each resident's record. Root Cause: (1) The failure to develop and implement behavior support plans within the required timeframe resulted from a lack of a structured process to ensure completion of behavior support plans within 30 days of admission. (2) Additionally, there was insufficient oversight	4/28/2026

License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **04-01-2026**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			to ensure all required components of the behavior support plan were completed and documented. Moving Forward: The provider has completed behavior support plans for Individual #1 and Individual #2, and techniques for managing anger and anxiety have been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure behavior support plans are developed and implemented within 30 days of admission. The Program Director will ensure that all behavior support plans include required components, including techniques for managing anger and anxiety. The Chief Administrative Officer will conduct monthly record reviews to ensure all behavior support plans are completed timely and maintained in compliance with 12VAC35-46-900. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing or incomplete behavior support plans. Plan Completion: Develop and implement behavior support plans for each resident, ensuring techniques for managing anger and anxiety are included. Tracking System Implementation: Develop and maintain a tracking log to ensure behavior support plans are completed within required timeframes. Ongoing Monitoring:	

License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **04-01-2026**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all behavior support plans are completed within required timeframes and include required components, including techniques for managing anger and anxiety. OLR) Accepted 04/23/2026	
12VAC35-46-900. A. (5) - Within 30 days of admission, the provider shall develop and implement a written behavior support plan that allows the resident to self-manage his own behaviors. Each individualized behavior support plan shall include: 5. Identification of interventions that may escalate inappropriate behaviors.	N	Lighthouse 1, LLC This regulation was NOT MET as evidenced by: Upon review of Individual #1 and Individual #2's records, the provider failed to develop and implement a written behavior support plan.	PR) 04/22/2026 The corrective action plan regarding the development and implementation of behavior support plans identifying interventions that may escalate inappropriate behaviors: The provider failed to develop and implement a written behavior support plan that included identification of interventions that may escalate inappropriate behaviors for Individual #1 and Individual #2 within the required timeframe. The behavior support plans have now been completed, and identification of interventions that may escalate inappropriate behaviors has been included and placed in each resident's record. Root Cause: (1) The failure to develop and implement behavior support plans within the required timeframe resulted from a lack of a structured	4/28/2026

License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **04-01-2026**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			process to ensure completion of behavior support plans within 30 days of admission. (2) Additionally, there was insufficient oversight to ensure all required components of the behavior support plan were completed and documented. Moving Forward: The provider has completed behavior support plans for Individual #1 and Individual #2, and identification of interventions that may escalate inappropriate behaviors has been included in each resident's record. Moving forward, the Chief Administrative Officer will implement a tracking system to ensure behavior support plans are developed and implemented within 30 days of admission. The Program Director will ensure that all behavior support plans include required components, including identification of interventions that may escalate inappropriate behaviors. The Chief Administrative Officer will conduct monthly record reviews to ensure all behavior support plans are completed timely and maintained in compliance with 12VAC35-46-900. Corrective Action Steps: Record Review: Conduct a review of all resident records to identify any missing or incomplete behavior support plans. Plan Completion: Develop and implement behavior support plans for each resident, ensuring identification of interventions that may escalate inappropriate behaviors is included.	

License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **04-01-2026**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date
			Tracking System Implementation: Develop and maintain a tracking log to ensure behavior support plans are completed within required timeframes. Ongoing Monitoring: Conduct monthly audits of resident records to ensure compliance. Responsible Person(s): Chief Administrative Officer and Program Director Completion Date: April 28, 2026 Monitoring Plan: The Chief Administrative Officer will conduct monthly record audits using a tracking log to verify that all behavior support plans are completed within required timeframes and include required components, including identification of interventions that may escalate inappropriate behaviors. OLR) Accepted 04/23/2026	

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN

License #: **4267-14-008**
Organization Name: **Lighthouse 1, LLC**

Date of Inspection: **04-01-2026**
Program Type/Facility Name: **14-008 Lighthouse 1, LLC**

Standard(s) Cited	Comp	Description of Noncompliance	Actions to be Taken	Planned Comp. Date

General Comments / Recommendations:
Please make sure to include the following in your Corrective Action Plan response:

1. Please identify the root cause(s) of the violation;

2. Develop a systemic plan of action, if applicable, to address the citation, which may require updating policies, procedures, and forms, or conducting any needed training or retraining for staff or other steps that could alleviate the problem and minimize the possibility that the violation will occur again;

3. Indicate the frequency for monitoring the plan, including how it will be monitored (Ex. monthly audits, weekly chart reviews, quarterly checklist).

4. Identify the staff position(s) responsible for monitoring implementation of the approved CAP.

5. Include a date of completion for each corrective action.

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Jennifer Thomasson, Regional Manager	(Signature of Organization Representative)	Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined