

RI Department of Health

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|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ALR01500</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/12/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LIGHTHOUSE AT LINCOLN</b> |                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>425 ALBION ROAD</b><br><b>LINCOLN, RI 02865</b> |                                                                                                                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                           |
| S 003                                                            | Initial Comments<br><br>An unannounced complaint/incident investigation survey, ACTS reference numbers, 95062, 95079, 95288, 95624, 95663, 95930, 95952, 95994, 96082, and 96144 was conducted at this residence on 6/12/2024. No deficiencies were identified. | S 003                                                                                       |                                                                                                                          |                                                                    |

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE