

RI Department of Health

|                                                                   |                                                                                                                                                  |                                                                                             |                                                                                                                          |                                                                    |
|-------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>ALR01474</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>06/27/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE SAKONNET BAY</b> |                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1215 MAIN ROAD</b><br><b>TIVERTON, RI 02878</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 was conducted at this residence. No deficiencies were identified. | S 003                                                                                       |                                                                                                                          |                                                                    |

Facilities Regulation

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

TITLE

(X6) DATE