

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ALR01468</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/13/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ATRIA LINCOLN PLACE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>612 GEORGE WASHINGTON HIGHWAY LINCOLN, RI 02865</b>
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(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
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S 003	<p>Initial Comments</p> <p>An unannounced complaint/incident investigation survey, ACTS reference numbers 102373, 102389, was conducted at this residence on 11/13/2025 to determine compliance with state regulations. No deficiency was identified.</p>	S 003		
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Facilities Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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