RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R **02/17/2021**

NAME OF PROVIDER OR SUPPLIER **WINGATE RESIDENCES ON THE EAST SIDE**	STREET ADDRESS, CITY, STATE, ZIP CODE **ONE BUTLER AVENUE** **PROVIDENCE, RI 02906**

(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
{S 003}	Initial Comments A follow-up survey to a complaint investigation survey and a new complaint investigation survey (GV2Z11, 02/17/2021) were conducted at this residence. No deficient practice was identified.	{S 003}		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01513	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED **02/17/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINGATE RESIDENCES ON THE EAST SIDE	**ONE BUTLER AVENUE** **PROVIDENCE, RI 02906**

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S 003	Initial Comments An unannounced complaint/incident investigation survey and a follow-up to a COVID-19 infection control survey (3KB812, 2/17/2021) were conducted at this residence. No deficient practice was identified.	S 003		

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE