

RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALR01515	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/18/2025
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NAME OF PROVIDER OR SUPPLIER HALCYON AT WEST BAY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2783 WEST SHORE ROAD WARWICK, RI 02889
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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
S 003	<p>Initial Comments</p> <p>An unannounced complaint/incident investigation survey, ACTS reference numbers 102514, 102340, 102473, and 102492, were conducted at this residence on 11/18/2025 to determine compliance with state regulations. No deficiency was identified.</p>	S 003		

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