NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARLINGTON ASSISTED LIVING CENTER NO	123 ARMISTICE BOULEVARD PAWTUCKET, RI 02860

(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 An unannounced complaint/incident investigation survey, ACTS reference numbers 102261, was conducted at this residence on 10/20/2025-10/22/2025 to determine compliance with state regulations. Deficiencies were identified.	S 003		
S 300	Residency Requirements 2.4.14.C.2 Residency Requirements 2.4.14 (C)(2) Residency Agreement or Contract 2. The residency agreement or contract shall include (or reference other documents that include) no less than the following items: a. Resident's rights; b. Admission criteria; c. Discharge criteria; d. Discharge policies; e. Description of the unit to be rented by the resident; f. Description of shared space and facilities; g. Services to be provided; h. Services that can be ~~arranged~~; i. Financial terms between resident and residence; (1) Basic rates; (2) Extra charges at signing;	S 300	S300 - Due to Legal ramifications Darlington had to re-admit ID#1 despite safety concerns. 10/17/25 11/28/25 - 30-Day notice re-issued on 10/22/25 10/22/25- for safety concerns. Behavioral contract issued. - Darlington will be more selective during admission process. 10/20/25	

Facilities Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Sanford | TITLE: Administrator | (X6) DATE: 11/13/25

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S 300	Continued From page 1 (3) Extra charges that may apply in the future; (4) Deposits and advanced fees; (5) Rate increase policy. j. Special care provisions (as applicable); k. Resident's responsibilities and house rules; l. Initial and on-going assessment and service plan; m. Grievance procedure. This Requirement is not met as evidenced by: Based on record review, surveyor observation, and staff interview, it has been determined that the residence retained a resident that does not meet the definition of a "resident" for one of one sample residents reviewed for appropriateness of residency, Resident ID #1. Finding are as follows: Per the Rules and Regulations for Licensing Assisted Living Residences, 2.4.14(C) 2 states in part,"...the residency agreement shall include services to be provided and services that can be arranged..." The Rhode Island Department of Health received a residence reported allegation of a resident that was experiencing hallucinations and a potential medication overdose on 10/9/2025 resulting in hospital admission. Record review revealed Resident ID #1 was	S 300		

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S 300	Continued From page 2 admitted to the residence in November of 2024 with a diagnosis that inlcudes, but is not limited to, major depressive disorder. Record review of a progress note dated 10/9/2025 revealed that the resident was sent to the hospital related to increased confusion and hallucinations. Further record review of a progress note dated 10/2/2025 revealed that the resident was prescribed Vynase (a medication used to treat attention deficit disorder), and that the residence is unable to administer that medication as it is a schedule II medication due to the risk of the medication being abused and a licensed nurse must administer all doses. Record review of an undated document titled, 'Brown University Health' states in part, "...the resident is under my care and given the facility's limitations, s/he can self-administer his/her medication safely..." During a surveyor interview on 10/20/2025 at approximately 11:30 AM with the Director of Nursing Services, she revealed on 10/6/2025 in the resident's locked box there were 14 Vynase tablets, subsequently on 10/9/2025 when she went to assess the resident, as the staff had reported s/he was confused, there were 7 Vynase tablets on his/her bed. Record review of a document titled State of Rhode Island Level II PASRR-MI (a required screening document to assess if an individual who is being admitted to a Medicaid certified facility is screened for a mental illness), states in part,"...ALF [Assisted Living Facility], unable to return, safety concerns ...Medication	S 300		

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S 300	Continued From page 3 management ...safety concern for a higher level of care..." Additional review of the documet revealed that the resident was unable to give consent for the PASRR to be completed due to his/her cognition and a family member was required to give consent. The residence was cited previously on 9/5/2025 due to safety concerns and the appropriateness of this placement as the resident had possession of multiple knives, medications and marijuana found in his/her room that had been purchased, not prescribed, and being found wandering along a beach in Revere, Massachusetts lost. S/he was sent to a local hospital for an evaluation and tested positive for cannabis and amphetamines. Additionally, at the time of the hospitalization it was recommended that s/he be transferred to a secure unit for safety and behaviors. During a surveyor interview on 10/20/2025 at approximately 12:30 PM with the resident, s/he had a bottle of acetaminophen 500 milligram tablets in his/her drawer, without a physician order to self-administer the medication. During a surveyor interview on 10/20/2025 at approximately 1:00 PM with the Director of Nursing Services, she was unaware the resident had the medication in his/her room. During a surveyor interview on 10/20/2025 at approximately 3:30 PM with the Administrator, she acknowledged that the resident's behaviors pose a safety concern and that s/he is not in an appropriate living arrangement.	S 300		
S 560	Residential Care Services 2.4.24.A.3.b Medication Services	S 560		

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S 560	Continued From page 4 2.4.24 (A) (3) (b) Medication Services b. For assisted living residences licensed at the M1-level, licensed employees (registered medication aides, registered nurses, licensed practical nurses) may administer oral or topical drugs and monitor health indicators. However, schedule II medications shall only be administered by licensed personnel. The physician or nurse supervisor shall conduct and document quarterly evaluations of the registered medication aides who are administering drugs and place a copy in the employee's personnel record. This Requirement is not met as evidenced by: Based on record review and staff interview it has been determined that the residence has failed to have a licensed personnel staff member administer a schedule II medication for one of one resident reviewed who is prescribed a schedule II medication, Resident ID#1. Findings are as follows: Record review revealed the resident was admitted to the residence in November of 2024 with a diagnosis that includes, but is not limited to, major depressive disorder. Further record review of a progress note dated 10/2/2025 revealed that the resident was prescribed Vynase (a medication used to treat attention deficit disorder), and that the residence is unable to administer that medication as it is a schedule II medication due to the risk of the medication being abused and a licensed nurse must administer all doses.	S 560	S560 Admin removed ID#1 control 2 med from the med cart, since facility can't administer. Physician was notified immediately. — DOW S560 — Admin updated facilities Interagency form now indicates Facility does not allow Schedule II narcotics. S560 — Admin also called W.C. Pharmacy & pharmacy will not send Schedule II narcotics to Facility.	10-2-25 10-6-25 10-6-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01324	A. BUILDING: _____ B. WING _____	C 10/22/2025

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S 560	Continued From page 5 Record review of the Medication Administration Record (MAR) revealed the following: -8/16/2025 through 9/16/2025 Vyvanse 30 milligram (mg) tablet was administered by a medication aide daily, not a licensed personnel staff member. Record review of a progress note dated 9/17/2025 revealed Vyvanse was increased from 30 mg to 40 mg daily. - 9/17/2025 through 9/30/2025 revealed Vynase 40 mg was administered by a medication aide daily. Record review of a progress note dated 10/2/2025 revealed that a pharmacist notified the residence that they were unable to administer Vyvanse because the residence is licensed as a M1 assisted living residence (a licensure requirement for one or more residents who require central storage and/or administration of medications) and that a schedule II medication can only be administered by a licensed staff member. Record review of a progress note dated 10/2/2025 revealed that the residence notified the prescriber that Vynase would be held due to the inability of the residence to administer it. During a surveyor interview on 10/20/2025 at approximately 12:30 PM with the Director of Nursing Services, she acknowledged that a medication aide was administering the schedule II medication from 8/16/2025-9/30/2025.	S 560 S560 – Admin re-educated DOW regarding regulations. 10-2-25 S560 – Management will discuss in QA meetings (quarterly) 12/2/25 CM 11/28/25	