RI Department of Health

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 09/05/2025

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 101668, 101779, 101780, 101822, 101805, and 101897, was conducted at this residence on 9/2/2025 - 9/3/2025 to determine compliance with state regulations. A deficiency was identified.	S 003	CONFIDENTIAL NOT PUBLIC KNOWLEDGE TIL 9.26.25	
S 230	Organization And Management 2.4.13.A Management Of Services 2.4.13 (A/B) Management of Services A. Each residence shall provide services with adequate professional and ancillary employees and in accordance with applicable state law. Further, the residence shall assure that all services are rendered in a safe and effective manner and consistent with the requirements herein. The residence shall provide all care and services to all residents in accordance with the prevailing community standard of care. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to provide care and services in accordance with prevailing community standards of care relative to administering medications per physician's orders for 1 of 7 resident's reviewed, Resident ID #1 and 2 of 7 residents reviewed for appropriate placement in a traditional assisted living setting, Resident ID#s 2 and 3. Findings are as follows: Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe	S 230	Received SEP 25 2025 Facilities Regulation	

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S 230	Continued From page 1 the orders are in error or would harm the clients." 1. Record review revealed Resident ID #1 was admitted to the residence in January of 2024 with a diagnosis including, but not limited to, paranoid schizophrenia. Record review of a physician's order dated 7/8/2025 revealed a change in dose of Clozapine (medication for the treatment of schizophrenia) from 150 mg (milligrams) to 200 mg due to an increase in behaviors. Record review of Resident ID #1's MAR (medication administration record) for July 2025 revealed the resident received 100 mg of Clozapine versus 200 mg from 7/8/2025 through 8/1/2025, per the physician's order. Record review of progress notes revealed the following: -7/29/2025, the resident was experiencing increased anxiety -7/30/2025, a call was made to the resident's social worker regarding his/her increased anxiety and an appointment was scheduled at the Clozapine clinic on 8/6/2025 -8/5/2025, 200 mg Clozapine was ordered; the resident was to receive two 100 mg tablets During a surveyor interview on 9/3/2025 at 12:15 PM with the Administrator and the Director of Nursing Services, they acknowledged the resident was given the wrong dose of Clozapine and that the physician's orders were not followed, resulting in the resident being sent out to a higher level of care. 2. Record review revealed Resident ID #2 was	S 230	Resident #1 S230 Admin RE-educated staff regarding CMT Duties (medication) - Employees written up & Admin closely monitoring them. 8/5/25 S230 DOW/Supervisor will put sticker on blister (MAR) 8/1/25 when orders are changed, to ensure staff are aware. 8/4/25 S230 Continued quarterly education to all CMTs 8/2/25	

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S 230	Continued From page 2 admitted to the residence in May of 2025 with diagnoses that include, but are not limited to, memory loss and seizures. Record review of a document titled, "Assisted Living Assessment" dated 5/12/205, indicates that the resident was being moved from a secure memory care unit to an unsecure traditional assisted living residence. Record review of physician's orders failed to reveal a physician order indicating the resident could be transferred from a secured memory care unit to a traditional assisted living residence and that the setting was a safe and appropriate level of care for the resident. During a surveyor interview on 9/3/2025 at approximately 11:00 AM with the Administrator, she was unable to provide evidence that a physician order was obtained to transfer the resident from a locked unit in an assisted living residence to a traditional assisted living residence. 3. Record review of Resident ID #3 was admitted to the residence in November of 2024 with a diagnosis that includes, but is not limited to, major depressive disorder with psychotic features. Record review of progress notes revealed the following: -8/17/2025, resident very forgetful, request for physician evaluation and cognative testing -8/21/2025, multiple knives, medications, and marijauna found in resident's room -8/25/2025, elder was found in Revere, Massachusetts wandering along a beach lost; on 8/23/2025 was sent to a local hospital for	S 230 S230 Resident #2 9/30/25 S 230	# Admin had a meeting c Resident #2 case worker (Gateway), physician, Admin, & DOW regarding [redacted] memory loss. N.P would like Resident #2 to see a Neurologist for further evaluation. Appt is scheduled. - Admin made corrections to Provider Plan of Care indicating whether Residents will need Traditional ALF or Special Care Unit,	9/18/25 9/19/25

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S 230	Continued From page 3 evaluation, at which time they called the Administrator of the residence Additionally, the hospital indicated the elder belonged in a secured unit; she/he tested positive for cannabis and amphetamines the hospital. Record review failed to reveal the residence contacted the physician regarding the resident being found out of state, wandering, and testing positive for cannabis and amphetamines. Additionally, the record failed to reveal the resident was transfered to a secure unit per the recommendation of the hospital due to his/her safety risk and behaviors. During a surveyor interview on 9/3/2025 at 11:15 AM with the Administrator, she was unable to provide evidence that the physician was contacted regarding the resident being found wandering a beach out of state and that she/he tested positive for amphetamines and cannabis when evaluated at the hospital.	S 230 S230 Resident #3 S230 @ 9/3/25 S230	Residents PCP was notified on 8/25/25 regarding Resident #3 ED visit in Mass. E.D informed Admin she was safe to return to traditional ALF. Admin made corrections to provider plan of Care indicating whether residents will need traditional ALF or Special Care Unit Upon Admission Admin oversees so she can ensure form is completed & DOW can overlook as well	8/25/25 9/19/25 9/19/25