RI Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALR01461	A. BUILDING: _____ B. WING _____	C 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DARLINGTON MEMORY LANE	1081 MINERAL SPRING AVENUE NORTH PROVIDENCE, RI 02904

(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 complaint investigation survey, ACTS reference numbers 102280, 102320, 102590, 102635, and 102671, was conducted at this facility on 12/17/2025. Deficiencies were identified.	S 003	Received JAN 07 2025 Facilities Regulation	
S 405	Residency Requirements 2.4.17.G.1. Resident Assessment/Service Plans 2.4.17 (G) (1) Service Plans 1. Within a reasonable time after move-in, not to exceed seven (7) days, the Administrator shall be responsible for the development of a written service plan based on the initial assessment. The service plan shall include at least: a. The services and interventions needed, including all services provided by outside healthcare agencies (e.g., home nursing care, hospice); b. Description, frequency, duration relating to the service or intervention, including personal assistance, medication, special diets, recreational activities, and other similar services rendered; c. Party responsible for arranging and/or providing the service; and d. The resident ' s requested and/or therapeutically needed recreational and social activities. This Requirement is not met as evidenced by: Based on record review and staff interview, it has been determined that the residence failed to accurately reflect the services and interventions needed on the service plan for three of five	S 405	SP were updated same day on residents 1, 3, & 4 SP will reflect upon admission IF they smoke. DOW recognizes SP was not updated to reflect residents anger problem, altercation, & services to minimize residents anger. DOW ensures moving forward SP will reflect any changes, including residents who smoke. Management will continue to discuss in weekly meetings	12-18-25 12/18/25 12/18/25 12-22-25

Facilities Regulation

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

Melissa Sanford — Executive Director — 1/6/2026

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S 405	Continued From page 1 needed on the service plan for three of five residents reviewed, Resident ID #s 1,3, and 4. Findings are as follows: 1. Record review of a residence reported incident to the RI Department of Health on 12/9/2025 alleged that Resident ID #1 was involved in an altercation with another resident. Record review of a medical provider's note dated 10/2/2025 stated in part, "...[the resident] has anger problems..." Record review of a medical provider's note dated 12/10/2025 stated in part, "...[the resident] has been having anger problems. Other people have been hit/struck..." Record review of the resident's service plan dated 10/16/2025 failed to be updated to reflect the altercation and the services to minimize anger. 2. Record review of Resident ID #3 revealed a document titled, "Safe Smoking Ability Assessment Form," revealed that the resident required assistance or supervision while smoking. Record review of the resident's service plan failed to reveal that resident was a smoker, required supervision when smoking, and interventions required to ensure the safety of residents at the facility relative to smoking. 3. Record review of Resident ID #4 revealed a document titled, "Safe Smoking Ability Assessment Form," revealed that the resident required assistance or supervision while smoking. Record review of the resident's service plan failed	S 405		

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S 405	Continued From page 2 supervision when smoking, and interventions required to ensure the safety of residents at the facility relative to smoking. During a surveyor interview on 12/17/2025 at approximately 2:30 PM with Staff A, Registered Nurse, she acknowledged that the service plan did not address the anger issues with interventions for Resident ID #1 and that the service plans did not address smoking for Resident ID #s 3 and 4.	S 405		
S 560	Residential Care Services 2.4.23.C Dietetic Services 2.4.23 (C) Dietetic Services C. The food service in each residence shall comply with the appropriate requirements of R.I. Gen. Laws Chapters 21-27 and 21-31, Part 50-10-1 of this Title, Rhode Island Food Code, and such other applicable statutory or regulatory provisions. This Requirement is not met as evidenced by: Based on surveyor observation, record review, and staff interview, it has been determined that the facility failed to comply with all appropriate standards of the Rhode Island Food Code relative to the main kitchen. Findings are as follows: Record review of the 2022 Food Code published by the U.S. Food and Drug Administration Section 4-501-114 states in part, "...a chemical Sanitizer used in a Sanitizing solution for a manual or mechanical operation shall (C)(2) have a	S 560	Concentration of the sanitizer solution was corrected on the spot. - Dishwasher was fixed - Sanitizer solution was recalibrated & working properly - FSM will check concentration of Sanitizer Solution daily, & keep a log	12/18/25 12-31-25 12-31-25 1-7-26

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S 560	Continued From page 3 concentration as indicated by the manufacturer..." Record review of the manufacturer's guidelines for the use of a quartnary ammonium sanitizer is 200-400 PPM (parts per million). During a surveyor observation on 12/17/2025 at approximately 1:00 PM of the main kitchen, the pot and pan sink was being used to wash and sanitize dishware. The concentration of the sanitizing solution read less than the manufacturer's recommendation of 200 PPM. Immediately following the above-mentioned observation, the Food Service Director acknowledged the sanitizer was not at the appropriate concentration.	S 560		
S 925	Special Care License Requirements 2.5.2.L Specific Requirements 2.5.2 (L) Specific Requirements L. The Alzheimer Dementia Special Care Unit/Program shall provide a secure distinct living environment appropriate for the resident population. This requirement may include, but not be limited to, a locked unit, secured perimeter, or other mechanism to ensure resident safety and quality of life. The residence shall have elopement policies in place, specific to the Unit/Program. This Requirement is not met as evidenced by: Based on surveyor observation and staff interview, the residence failed to ensure an environment of safety of all residents residing on the memory care unit.	S 925	S925 Cart, Toilet Lid, & paint brush were corrected on site. Lid was put bk on Toilet (maintnance was repairing), cart was moved to laundry room, dried paint tray & brush was disposed in the garbage. 11/12	12-18-2

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S 925	Continued From page 4 Findings are as follows: During a surveyor observation on 12/17/2025 at approximately 12:45 PM, on the memory care unit, in the presence of the Administrator, the following was observed: - housekeeping cart with chemicals, which included, but not limited to, "Fabuloso (a household cleaner)" stored, unattended - bathroom door in corridor opened and the lid off the toilet tank - paint tray and roller brush in the resident corridor During a surveyor interview with the Administrator, immediately following the above-mentioned observations, she acknowledged that the housekeeping cart was not visible to the housekeeper, that the toilet tank lid was removed, and the paint tray and roller brush were inappropriately stored.	S 925	S925 – Supervisor upon doing rounds will ensure nothing hazadous in hallways. Maintenance was re-educated on leaving out any working supplies. S925 – Housekeepers re-educated on importance of storing chemicals properly, and while on the unit cart cant be unattended.	12-19-25 12-18-25 12-19-25 & 1-6-26