STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Crest at Meadow Ridge	100 Redding Road West Redding, CT 06896

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1), reviewed for a change in condition, the facility left unlicensed staff with a resident who was identified with a significant change in condition, and failed to ensure a resident's active do not resuscitate (DNR) order was honored when he/she was identified to have no pulse, no respirations, and had fixed and dilated pupils, and failed to ensure Emergency Medical Services (EMS) was notified prior to a pronouncement of death. The findings include: Resident #1 had a diagnosis of heart failure, hypertension (high blood pressure), atrial fibrillation (irregular heart rhythm), aneurysm of the heart (bulging area in the heart muscle), and rheumatic tricuspid insufficiency (heart not pumping blood effectively). The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition, and required maximal assistance ADLs and transfers. The Resident Care Plan (RCP) dated [DATE] identified a risk for decreased cardiac output, and code status was DNR (Do Not Resuscitate). Interventions directed to monitor for chest pain and shortness of breath, and do not administer cardio-pulmonary resuscitation (CPR). Physician order dated [DATE] directed DNR and RN May Pronounce (RNP) death. Nursing note dated [DATE] at 8:05 AM identified resident was last observed by staff at 2:30 AM in recliner. Resident prefers to sleep in recliner due to shortness of breath while laying down, related to CHF diagnosis. Resident's legs were noted to be edematous, and Resident #1 keeps legs elevated while in the recliner. Resident #1 walked unassisted to the opposite side of his/her bed to use the commode and had a fall after commode use. The call bell was noted on the armrest of recliner and was not on at the time of discovery. Nonskid socks were in place. Reportable event dated [DATE] at 2:58 AM identified NA #1 reported Resident #1 was on the floor at 2:45 AM. RN #1 responded to the room and observed Resident #1 lying on his/her left side on the floor with his/her head towards the foot of the bed and had minimal verbal responses. RN assessment was completed and RN #1 was in the process of getting paperwork together while the NAs obtained vital signs and the LPN #1 obtained oxygen. LPN #1 then notified RN #1 that Resident #1 had become unresponsive and was without a pulse. The RN #1 observed pupils were fixed and dilated, Resident #1 had no response to noxious stimuli, pulse was absent and respirations were absent for one (1) minute. Resident #1 was a DNR and RNP, and RN #1 pronounced death at 2:58 AM. The DNS was notified at approximately 3 AM (approximately 15 minutes after Resident #1 was found on the floor), the local police were notified at 3:04 AM, and EMS was contacted at 3:23 AM (approximately 38 minutes after Resident #1 was found on the floor). EMS contacted the local hospital emergency room doctor regarding Resident #1's DNR orders, and received clearance to accept the facility's DNR order and to not carry out any resuscitation efforts. Resident #1 was pronounced by the paramedic at 3:43 AM (45 minutes after RN #1 had pronounced death). The medical examiner declined the case and stated that the resident had a terminal collapse. Facility statement from RN #1 dated [DATE] identified after Resident #1 was found on the floor, she performed an assessment and identified Resident #1 had minimal verbal responses and was only moaning, and she made the decision to transfer to Resident #1 to the hospital. The statement indicated that during RN #1's preparation to call emergency services RN #1, was notified by the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	charge nurse (LPN #1) that Resident #1 became unresponsive and was without a pulse. RN #1 noted Resident #1 had DNR and RNP orders in place and she pronounced death at 2:58 AM. Review of EMS Fire District dispatch run sheet identified they were notified at 3:09 AM of a possible untimely and arrived at Resident #1 at 3:20 AM. Resident #1 was on the floor in her/his room, was warm to touch and had no pulses present. Nursing home staff informed EMS that Resident #1 had a hematoma to the left side of his/her head and was on a blood thinner. Staff reported Resident #1 was a DNR and had been on the floor for about 30 minutes before the ambulance arrived. Med control was called to see if the DNR was valid and informed the physician of the situation and the doctor directed to follow the DNR. The staff then informed EMS that Resident #1 was seen at 2:30 AM and then 15 minutes later staff heard moaning from the room and Resident #1 was found on the floor with agonal respirations (slow, gasping, or snoring-like breaths that occurs during severe medical emergencies). EMS rolled Resident #1 onto his/her back and observed a wound on the left side of his/her head with blood around the area. No lung or heart sounds were heard, and EMS noted the beginning of rigor (temporary muscle stiffness that occurs after death) in the jaw. Medic arrived on scene and was informed of the incident, and the [NAME] gave the time of death as 3:43 AM. Review of local police Medic (paramedic) identified they were dispatched at 3:12 AM and arrived at Resident #1 at 3:38 AM. Resident #1 was found to be pulseless and apneic (without respirations) by EMS, and had an active DNR order. Resident #1 was observed unresponsive, had no respirations, no pulses at the carotid (neck), femoral (groin) and radial (wrist) and no heart signs. Medic was presented with an active DNR order and Resident #1 was wearing a DNR bracelet on the left writs. Resident #1 had a hematoma noted on the right forehead, with no additional obvious trauma noted. Although attempted, RN #1 was unavailable for interview during the survey. Interview and record review with NA #1 on [DATE] at 12:41 PM identified she last saw Resident #1 at 2:30 AM and then about 2:45 AM or 2:50 AM she observed Resident #1 on the floor. NA #1 asked Resident #1 if he/she was okay, and Resident #1 did not respond and she then left the room to notify the nurse. Interview and record review with LPN #1 on [DATE] at 12:10 PM identified he was entering Resident #1's room as RN #1 left the room to call 911. LPN #1 proceeded into Resident #1's room and observed two (2) NAs were in the room and Resident #1 was on the floor unresponsive with no pulse or respirations. LPN #1 then left the room to obtain the crash cart and notify RN #1 that Resident #1 no longer had a pulse or respirations, leaving Resident #1, unresponsive, with two (2) NA's (unlicensed staff) in the room. LPN #1 stated when he returned to the room with the crash cart, he started providing rescue breaths to Resident #1 because it was non-invasive and Resident #1 had a signed DNR, and CPR could not be performed. LPN #1 stated he gave rescue breaths for approximately two (2) minutes, and then RN #1 pronounced Resident #1's death. RN #1 called 911 after she pronounced the death. Interview failed to identify why LPN #1 left the room to obtain the crash cart and did not send one (1) of the NAs for the cart. Interview and record review with the DNS on [DATE] at 1:05 PM identified she was notified about 3 AM that Resident #1 had a fall and had expired. Resident #1 was last seen about 2:30 AM, and NA #1 responded to the room when she heard a noise, and found Resident #1 on the floor. NA #1 notified RN #1/supervisor and when RN #1 assessed Resident #1, he/she was moaning and crying and RN #1 called EMS. LPN #1 entered the room as RN #1 was exiting the room. LPN #1 observed Resident #1 had no pulse or respirations, and LPN #1 left the room to notify RN #1 and to get the crash cart. When LPN #1 left the room, he left two (2) NAs in the room with Resident #1, who was unresponsive with no pulse or respirations. LPN #1 returned to the room and started rescue breaths, and then RN #1 pronounced the death at 2:58 AM. RN #1 called the DNS after Resident #1 was pronounced, and the DNS directed RN #1 to call EMS because it was an unanticipated death. The DNS stated LPN #1 should have stayed in the room with Resident #1 and should have delegated a NA to obtain the crash cart and notify the RN of the change in condition. Further, the DNS stated LPN #1 should not have performed rescue breaths because Resident #1 was a DNR. Although requested, the of facility did not provide a CPR Policy or Do Not Resuscitate Policy, for surveyor review. Review of the CT Public (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Health Code: 19a-580d-1 (5) directed in part, a Do Not Resuscitate order or DNR order means an order written by a Connecticut licensed physician to withhold cardiopulmonary resuscitation, including chest compressions, defibrillation, or breathing or ventilation by any assistive or mechanical means including, but not limited to, mouth-to-mouth, mouth-to-mask, bag-valve mask, endotracheal tube, or ventilator for a particular patient. Review of facility Post-Mortem Care, RN Pronouncement Policy dated March of 2023 directed staff in the event of an unanticipated death and if emergency medical services or hospice had not taken over procedures for the determination of death then staff are to call 911.