STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075429	A. Building B. Wing	05/07/2026

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for two of three residents (Resident #2 and #3) reviewed for quality of care, the facility failed to maintain the confidentiality and privacy of Resident #2 and #3, when their medication blister packs containing resident-identifying information was improperly included with Resident #1's discharge medications. The findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included falls, diabetes mellitus, and prostate cancer. Physician order dated 3/6/26 directed Abiraterone (used to treat prevent the production of Testosterone in the treatment of prostate cancer) 250 milligrams (mg), four tablets (1000 mg total), to be administered daily for the treatment of prostate cancer. Resident #3 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure, diabetes mellitus, atrial fibrillation, and anemia. Physician order dated 3/4/26 directed Potassium Chloride Extended Release 10 mEq (milliequivalents) tablets, to be administered daily for the treatment of congestive heart failure. Record review identified Resident #1 was discharged from the facility on 3/11/26. Review of photographs of medication blister packs sent with Resident #1 upon discharge from the facility, identified the medications included a blister pack labeled for Resident #2's Abiraterone (10 tablets), and a blister pack labeled for Resident #3's Potassium Chloride (30 tablets). Interview with Resident #1 on 5/7/26 at 10:10 AM identified following discharge from the facility on 3/11/26, Resident #1 reviewed the medications he/she was sent home with, and discovered medications prescribed for Resident #2 and Resident #3, including Abiraterone and Potassium Chloride, were improperly included with his/her discharge medication bag. Resident #1 subsequently notified the facility of the medication error. Interview with RN #1 on 5/7/26 at 12:15 PM identified she was unaware medications belonging to Resident #2 and Resident #3 had been improperly included in Resident #1's discharge medication bag at the time of discharge. Interview with the DON on 5/7/26 at 10:40 AM identified the facility became aware Resident #1 was discharged with medications belonging to Resident #2 and Resident #3 after notification from Resident #1. The DON stated the facility did not have a licensed staff member available to pick up the medications sent with Resident #1 in error, and Resident #1's family returned Resident #2 and Resident #3's medications to the facility on 3/12/26. The DON stated Resident #2 and Resident #3's medications should not have been sent home with Resident #1, and was unable to explain how they were included in Resident #1's medications upon discharge. The facility Transfer or Discharge, Resident-Initiated Policy directed in part, the information conveyed will include (resident) medications, including when last received. The facility did not provide a policy regarding resident confidentiality for surveyor review during the survey.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for discharge process, the facility failed to ensure the resident was discharged with all prescribed narcotic medications as ordered. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery and neuropathy. The Resident Care Plan (RCP) dated 3/8/26 identified Resident #1 at risk for pain, and a plan to be short-term stay (planned discharge to the community). Interventions directed pain evaluations as indicated, administer pain medication as ordered, and monitor pain every shift, and planned discharge to the community/home with potential services. Physician order dated 3/8/26 directed to administer Oxycodone 5 milligrams (mg) one (1) tablet every four (4) hours as needed for pain scale 4 to 7, and administer two (2) tables every four (4) hours as needed for pain scale 8 to 10. The 5-Day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (15/15), indicative of being cognitively intact, and received opioids within the last seven (7) days. Record review identified Resident #1 was discharged from the facility on 3/11/26. Nursing note dated 3/11/26 at 20:29 (8:29 PM) written by RN #1, identified Resident #1 was discharged home with medications and belongings, with teaching of medications. Narcotics were not given at the time of discharge. The note continued with a late entry addendum that indicated Resident #1 called the facility t 9:15 PM about how he/she needed Oxycodone, and he/she was in agony. RN #1 explained protocol of signing out the narcotics out and he/she hung up phone when given the option to have someone pick up medication the tomorrow morning. Review of the Post-Discharge Plan of Care/Resident Medication Profile (discharge paperwork), dated 3/11/26 at 4:04 PM identified Oxycodone was listed on the form as a medication directed for use upon discharge. The form directed Oxycodone 5 mg twice daily for seven days and Oxycodone 5 mg every four hours as needed for pain management upon discharge. Interview with Resident #1 on 5/7/26 at 10:10 AM identified Resident #1 was discharged from the facility on 3/11/26 with medications. When Resident #1 was going to self-administer his/her narcotic medication and reviewed his/her medications the facility supplied upon discharge (with the medication), he/she noted the pain medication (Oxycodone) was missing. Resident #1 called the facility and spoke with RN #1 who informed him/her that the narcotic medication needed to be signed out (when discharged). Resident #1 stated RN #1 had not advised Resident #1 of the requirement when he/she was discharged , and the Oxycodone was not sent home with Resident #1. Interview with RN #1 on 5/7/26 at 12:15 PM identified Resident #1 was discharged from the facility on 3/11/26 and RN #1 was responsible for completing the discharge process, including discharge education and medication reconciliation. RN #1 stated facility process required residents to receive education and sign for both routine and narcotic medications upon discharge. RN #1 stated she failed to properly educate Resident #1 regarding the narcotic medication and the need to sign-out the Oxycodone; RN #1 failed to ensure Resident #1 signed for and received the prescribed narcotic medication prior to discharge. RN #1 stated Resident #1 later contacted the facility reporting the narcotic medication had not been received and she gave instruction that the medication could be picked up at the facility. Interview with the DON on 5/7/26 at 10:40 AM identified Resident #1 abruptly self-discharged from the facility on 3/11/26, and nursing staff failed to ensure the prescribed narcotic medication (Oxycodone) was provided to Resident #1 at the time of discharge. The DON stated Resident #1's family subsequently returned to the facility on 3/12/26 to retrieve the Oxycodone. The DON further stated the facility practice required residents to receive prescribed narcotic medications upon discharge, unless refused by the resident. The facility Transfer or Discharge, Resident-Initiated Policy directed in part, the information conveyed will include (resident) medications, including when last (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received. Review of the undated facility Transfer or Discharge, Facility-Initiated Policy directed in part, documentation of transfer or discharge was to include disposition of medications.