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	03/24/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of staff interviews, review of the clinical record and facility documentation for 1 of 1 sampled residents reviewed for hospice services (Resident #29) and for 1 of 2 sampled residents (Resident #46) reviewed for death, the facility failed to ensure the Resident Care Plan (RCP) was comprehensive to include hospice care. The findings include: 1. Resident #29's diagnoses included dementia and Alzheimer's disease. A Resident Care Plan dated 9/18/24 identified Resident #29 had impaired cognition related to advanced dementia. Interventions included repeating instructions as necessary, maintaining as consistent a routine as possible, and keeping environmental stimuli to a minimum. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #29 had a short/long term memory problem and was dependent on staff for eating, oral hygiene, dressing and personal hygiene. A physician's order dated 12/6/24 directed to admit Resident #29 to hospice care. Interview and clinical record review on 3/19/25 at 7:55 AM with the MDS Coordinators (RN #3 and RN #4) identified that a care plan was not developed in regards to Resident #29 receiving hospice services and that it was the responsibility of the MDS department to implement a care plan once notified that a resident was receiving hospice. Additionally, the interview identified that social services would notify the interdisciplinary team when a resident was admitted to hospice and that when they receive notification, they would develop a care plan. Additionally, RN #3 and RN #4 indicated they did not receive notification that Resident #29 was admitted to hospice services. An interview and clinical record review on 3/19/25 at 9:15 AM with the Director of Social Services identified Resident #29's family member requested a consultation for hospice on 12/4/24 and that the resident was admitted to hospice on 12/6/24. Additionally, the interview identified that when a referral was made for hospice, social services would send out an email notification to the inter-disciplinary team. Once the referral was accepted and the resident was admitted to hospice, the social worker would send another notification to the interdisciplinary team. Additionally, the Director of Social Services stated email notification was sent to the interdisciplinary team on 12/4/24. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and clinical record review on 3/20/25 at 11:02 AM with the DNS identified that a hospice care plan for Resident #29 had not been implemented after admission to hospice on 12/6/24 and that it should have been developed per facility policy. Additionally, it identified that social services would send email notification to the interdisciplinary team when a resident was referred to hospice and then a follow-up notification when the resident was accepted. That would serve as notification for the MDS department to implement a care plan. It was identified that an email notification was sent from social services to the MDS department on 12/4/24 stating that a referral had been made to hospice for Resident #29, but there was not a follow-up email sent when the resident was accepted and admitted to hospice on 12/6/24. Subsequent to surveyor inquiry, a care plan for hospice was developed. The care planning-interdisciplinary team policy dated 3/2022 identified that the interdisciplinary team was responsible for the development of resident care plans. Review of the hospice program policy dated 7/2017 that it is the responsibility of the facility to administer prescribed therapies delineated in the hospice plan of care. 2. Resident #46 was admitted to the facility in April 2024 with diagnoses that included Parkinson disease, dementia, and anxiety. A Resident Care Plan dated 11/13/24 identified Resident #46 had a functional decline with interventions to evaluate range of motion, assess current functional level and complete the activities of daily living section on the Minimum Data Set (MDS) assessment. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #46 was cognitively intact and required partial/moderate assistance for eating and oral hygiene. Additionally, the MDS identified Resident #46 required substantial assistance for personal hygiene and was dependent for dressing, transfers, and toileting. A nursing notes dated 11/20/24 at 9:28 PM identified Resident #46 was admitted to hospice services. The Resident Care Plan (RCP) dated 11/20/25 failed to identify the RCP was comprehensive to include Resident #46 receiving hospice services. A nursing note dated 11/20/24 at 10:05 PM identified Resident #46 was sent to the hospital for agitation, being difficult to re-direct, swinging laptop and hitting staff. A nursing note dated 12/5/24 at 8:58 PM identified that Resident #46 returned to the facility from the hospital. The RCP dated 12/5/24 also failed to identify the RCP was comprehensive to include Resident #46 receiving hospice services. An interview and review of the RCP on 3/24/25 at 11:10 AM with the MDS Coordinator (RN #4) failed to identify that a care plan had been developed by the facility regarding hospice services. RN #4 further noted that the Director of Social Services was responsible for developing hospice plan of care. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/24/25 at 11:24 AM with the Director of Social Services identified that either the social worker or the MDS Coordinator was responsible for developing a care plan regarding hospice. Additionally, the MDS Coordinator noted that the RCP did not include Resident #46 receiving hospice services, was not sure of the reason a hospice care plan was not developed, but the facility policy was for one to be completed upon admission to hospice services. An interview with the DNS on 3/24/25 at 11:55 AM identified that a care plan for hospice services was not developed when hospice services were initiated on 11/20/24, and one should have been implemented. The care planning-interdisciplinary team policy dated 3/2022 identified that the interdisciplinary team was responsible for the development of resident care plans. 51101

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 48950 Based on the facility policy, record review, and interviews for 1 of 3 sampled residents (Resident #36) reviewed for accidents, the facility failed to ensure the Resident Care Plan was reviewed and revised after a fall with a major injury. Resident #36 was admitted to the facility in January 2025 with diagnosis that included heart failure, hypotension, and falls. A Fall Risk assessment dated [DATE] identified Resident #36 was a fall risk, and a fall prevention care plan was initiated or updated. The admission Minimum Data Set assessment (MDS) dated [DATE] identified was cognitively intact and was independent for eating, and oral hygiene. The MDS also, identified Resident #36 required partially moderate assistance for transfers, dressing, and was dependent for showering. The MDS further identified Resident #36 required touch supervision when ambulating. The Resident Care Plan (RCP) dated 1/3/25 identified Resident #36 was at risk for falls with interventions that included to complete a fall risk score, place call system and most frequently used items with in reach and provide orientation to room. Physician orders dated 1/21/25 directed that Resident #36 was able to ambulate in his/her room independently as well as toileting and transfer. A Reportable Event form dated 1/31/25 at 3:15 AM identified that Resident #36 was ambulating in his/her room independently when his/her walker hit the door. Further identifying that Resident #36 was independent with ambulation. Additionally, Resident #36 was found on the floor, bleeding from his/her head and sent to the hospital for evaluation. Nursing notes dated 1/31/25 at 3:47 AM identified that Resident #36 fell while trying to get to the bathroom, hitting his/her right side of head which was bleeding, and was sent to the emergency room . Nursing notes dated 2/11/25 at 8:40 PM identified that Resident #36 returned to the facility on [DATE] with a diagnosis of a left femur fracture, odontoid fracture, closed head injury, and a scalp laceration. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and review of the RCP on 3/19/25 at 12:15 PM with the DNS failed to identify the care plan had been reviewed/revised after Resident #36's fall with injury on 1/31/25. She further identified that the policy was for the Resident Care Plan to be updated after each fall, and that the Minimum Data Set Nurse and DNS were responsible for updating after the fall on 1/31/25. Further, the DNS identified that Resident #36 was out of the building for so long that it was an oversight that the Resident Care Plan was not updated to reflect the fall, and updating the Resident Care Plan was important because it could help to prevent further falls. Subsequent to surveyor interview, the care plan was revised on 3/19/25 by Registered Nurse #4 but the date of 3/5/25 was electronically entered as the created date (despite the care plan being updated on 3/19/25), and effective date listed as 2/12/25. The revised care plan identified Resident #36 was a risk for falls with interventions directed to place call system and most frequently used items within resident's reach, evaluate Resident #36's ability to understand the instructions provided, identify resident specific interventions to aid in the prevention of falls, communicate interventions via the resident summary and nursing assistant assignment sheet. Review of the Fall and Fall Risk Management policy identified that the interdisciplinary team, with input from the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls. Also, identified if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on observations, interviews, review of the clinical record, and facility policy for 1 of 4 residents (Resident #45) reviewed for pressure ulcers, the facility failed to ensure physician orders related to an air mattress included type of setting and ensure the air mattress was set correctly. The findings include: Resident #45 was admitted to the facility in February of 2025 and had diagnoses that included sepsis, pressure injury, encephalitis and chronic kidney disease. A Nursing Admission assessment dated [DATE] identified Resident #45 was admitted from the hospital to the facility, had a short-term and long term memory problem, had limited range of motion to both arms and both legs, was dependent for eating, required assistance of 2 staff members for toileting, had edema to both arms/legs, and had pressure injuries to the coccyx and buttock. The Resident Care Plan (RCP) dated 2/25/25 identified Resident #45 was at risk for alteration in skin integrity related to a State 3 pressure ulcer to the coccyx, a Stage 2 pressure ulcer to the left buttock, a low back surgical area, and perifungal rash. Interventions included to complete weekly wound evaluations, encourage side to side positioning, and a pressure reduction mattress on the bed. A physician order dated 2/25/25 directed to complete a weekly skin check under the evaluation tab in the electronic record every week starting on 2/25/25 and to obtain evaluation and treatment by a wound physician. Additionally, a physician order dated 2/25/25 directed to place an alternating air pressure relief mattress to the bed and adjust by Resident #45's weight or preferences. The physician order failed to identify instructions to ensure the mattress was set on alternate pressure mode and not static pressure mode. A Wound Assessment document dated 2/25/25 identified Resident #45 was admitted with pressure injuries to the coccyx and left buttock. The coccyx wound presented as a Stage 3, had a moderate amount of serosanguinous (SS) drainage, and measured 2 centimeters (cm) in height by 1.5 cm in width by 0.3 cm in depth. Additionally, the left buttock pressure ulcer presented as a Stage 2, had 100% non-granulated tissue, a small amount of SS drainage, and measured 3 cm in height by 3 cm in width by 0.2 cm in depth. The assessment further identified the pressure ulcer treatment to both areas was to cleanse with Normal Saline and pat dry, apply Medihoney (a topical wound treatment) followed by Calcium Alginate (a topical wound treatment), cover with a Silicone adhesive foam dressing, change the dressing 2 times a day, and ensure an air mattress was in place (but failed to identify the type of setting, alternating air or static). A physician order dated 2/27/25 directed to cleanse the coccyx and left buttock with normal saline and pat dry, apply Medihoney followed by calcium alginate, cover with a Silicone adhesive foam dressing, change the dressing 2 times a day, and ensure air mattress was in place (but failed to identify the type of setting, alternating air or static). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Wound progress note dated 3/3/25 and written by MD #1 identified she was requested to provide a wound consultation for Resident #45. Resident #45 had a Stage 3 coccyx pressure injury to the coccyx and noted the wound base was 75 to 99% granulations, had no odor, moderate amount of SS drainage and measured 1 cm by 1 cm by 0.2 cm. Additionally, Resident #45 had a pressure injury to the left buttock which now presented as unstageable, had a 100% brown crusty wound bed, moderate amount of SS drainage, and measured 3.5 cm by 3.5 cm by 0 1 cm. The assessment further identified the treatment was to cleanse the left buttock with normal saline and pat dry, apply Santyl (topical debriding wound treatment) followed by calcium alginate, cover with a silicone adhesive foam dressing, change the dressing 2 times a day, and ensure air mattress was in place. The note further identified treatment recommendations to both areas was to cleanse the wounds, apply Santyl (wound debriding ointment) followed by Calcium Alginate to the base of the wound, secure with a dry clean dressing, and change the dressing 2 times a day. A wound progress note written by MD #1 on 3/17/25 identified she saw Resident #45 for evaluation and management of his/her pressure injuries to the left buttock and coccyx. The note identified the coccyx and left buttock pressure injuries had bridged (merged) into a single wound and documentation going forward would be as a single wound under location of left buttock. The note further identified the bridged left buttock pressure injury was unstageable, the wound base contained 75-99% slough and 1-24% granulation, had no odor, had a moderate amount of serous drainage, and measured 3 cm by 4 cm by 0.1 cm. A physician order dated 3/17/25 directed to cleanse the left buttock unstageable pressure injury with Normal Saline and pat dry, apply Santyl (wound debriding ointment) followed by Calcium Alginate, cover with a Silicone adhesive foam dressing, change the dressing 2 times a day, and ensure air mattress was in place (but failed to identify the type of setting, alternating air or static). Observation on 3/18/25 at 9:15 AM and on 3/18/25 at 10:22 AM identified Resident #45 lying supine in bed on an air mattress with both arms elevated on pillows. The air mattress' pressure adjustment knob was set between 180 and 210 and static mode engaged (Resident #45 weighed 192.0 pounds). Observation on 3/18/25 at 10:48 AM identified 2 Nurse Aides (NA) entered Resident #45's room to provide care. Resident # 45 was provided morning care with an incontinent brief change and Resident #45 was dressed. Resident #45 was then positioned supine in bed with both arms elevated on pillows. An air mattress was in place on the bed with the pressure adjustment knob set between 180 and 210 and static mode engaged. An interview with the Assistant Director of Nursing Services (ADNS) on 3/19/2025 at 10:06 AM identified alternating pressure air mattress settings were set by the resident weight and that she does not touch the static/alternate button on the mattress pump. Observation on 3/19/25 at 11:19 AM identified Resident #45 lying supine in bed with the head of bed (HOB) at 30 degrees and both arms elevated on pillows. There was an air mattress in place on the bed with the pressure adjustment knob set between 180 and 210 and static mode engaged. An interview with Registered Nurse (RN) #1 on 3/20/25 at 10:04 AM identified there were physician orders to check the alternating pressure air mattresses every shift for function and weight setting. RN #1 identified she verified the setting using the resident's most recent weight in the computer and that she did not touch the static/alternate button as that wasn't part of the order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/24/25 at 9:42 AM, on 3/24/25 at 10:21 AM and at 12:15 PM identified Resident #45 was lying supine in bed on an air mattress with the HOB at 90 degrees. The air mattress' pressure adjustment knob was set between 180 and 210 and static mode engaged. An interview with Occupational Therapist (OT) #1 on 3/24/25 at 10:50 AM identified Resident #45 did not get out of bed for long periods of time at the request of the nursing department due to the presence of pressure wounds. She identified that Resident #45 would get out of bed for therapy before lunch and then Resident #45 would go back to bed shortly after lunch. An interview with MD #1 on 3/24/25 at 10:58 AM identified air mattresses were put in place for residents at high risk for skin breakdown especially for residents with limited mobility putting them at high risk for skin breakdown to the heels and buttocks. MD #1 identified she deferred to the facility for their protocol for the settings for the air mattresses used within the facility, but that usually the settings were set by the facility based on the resident's weight. MD #1 identified that use of the alternating pressure mode versus static pressure mode settings on the facility air mattresses depended on the mattress type and the manufacturer recommendations. The Treatment Administration Record dated 3/1/25 through 3/31/25 identified the physician order for an alternating pressure relief mattress adjusted by Resident #45's weight or preferences was signed off every shift by the nurses (but failed to identify the type of setting, alternating air or static). Interview with the DNS on 3/24/25 at 1:48 PM identified the air mattresses used by the facility were set based on resident weight and preferences. The DNS identified that all the facility air mattresses were alternating pressure air mattresses and she was not aware that several of the facility air mattresses, including Resident #45's were set to the static mode, and not alternating pressure mode. The DNS further identified the alternating pressure function should be in place at all times (and not the static function) to provide wound prevention and healing by limiting the pressure in one area on the resident's skin for extended periods. An interview with the Direct Home Medical Provider of equipment Clinical [NAME] President (the company of the air mattress used for Resident #45) on 3/27/25 at 1:27 PM identified that it was not correct practice to keep the air mattress set at the static pressure mode for long periods of time. Additionally, the Direct Home Medical Provider of equipment [NAME] President identified that air mattresses were dual therapy and provide both low air loss and alternating pressure to prevent and manage wounds. She indicated that when a resident required the use of a brief for incontinence and had a draw sheet or pad on top of the mattress those extra layers negated the benefits of the mattresses low air loss and the alternating pressure function of the mattress would then take over as the main feature to prevent and manage wounds. Additionally, the Medical Provider [NAME] President identified that use of the static pressure mode was intended for only short periods such as while providing care or during meals to provide extra support while the resident was sitting upright to eat, but that the mattress should then be returned to the alternating pressure mode when those activities were completed. Also the interview identified keeping the air mattress setting on the static pressure mode consistently for long periods of time would contribute to wound deterioration or the development of a wound for a resident at risk for skin breakdown. Also, the Direct Home Medical Provider of equipment [NAME] President further identified that the suppliers providing the air mattresses to the facility were responsible for providing education to the facility on the proper use of all functions of the air mattresses. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Air Element Mattress Owner's Manual identified on page 9 of the manual that the alternate/static switch selects between alternate pressure mode and static pressure mode. The manual identified with alternate pressure mode, alternating air cells are partially deflated and inflated, avoiding prolonged pressure on any single point beneath the resident to help prevent pressure ulcers. The manual further identified with the static pressure mode, all of the air cells are equally inflated.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47489 Based on observation, review of facility documentation, review of facility policy/procedures and interviews for medication storage and narcotic reconciliation, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of controlled medication and failed to ensure that an account of all controlled drugs was maintained and periodically reconciled. The findings include: On 3/19/25 at 11:03 AM, review of the narcotic reconciliation and audit procedure with the DNS identified she was responsible for narcotic monitoring to include reconciliation and facility audits. The DNS described the facility audits the same as shift to shift counts on the unit medication carts. The DNS indicated she didn't have a regular process for reconciliation and that the last audit was completed in May 2024. Additionally, the DNS indicated an audit was only completed on the Omnicell (a secured machine that contains medication) and not the medication carts on the units or controlled medication in the emergency box. The DNS identified that when the nurses receive a delivery of medication from the pharmacy, they sign for the narcotics and place the yellow copy of the Controlled Substance Disposition Record (CSDR) into the DNS inbox and the white copy goes on the unit medication cart with the medication. If the medication was finished, discontinued, or needed to be destroyed, the white copy was given to the DNS and matched up with the yellow sheet, reconciled and if needed, the medication destroyed. The DNS identified that neither the yellow copies of the CSDRs nor the inventory slips were used in confirming reconciliation of narcotics. Additionally, delivery slips from the pharmacy were sometimes kept on the unit and discarded after a while and not reviewed/reconciled with the yellow copy. The DNS indicated that medications were obtained from other pharmacies or brought in as personal medications and were kept on the unit medication carts with a facility created medication count sheet that was kept with the medication. There were no corresponding yellow copies for accountability. The DNS indicated that if a narcotic was thought to be missing, she would be able to ask the pharmacy for a receipt of delivery but couldn't answer about personal medication brought from home. Although requested, narcotic audit or reconciliation documentation was not provided by the facility. The facility policy for Inventory control of controlled substances (5.4) identified a facility representative should regularly check the inventory records to reconcile inventory to include current and discontinued inventory of controlled substances to the log used in the facility's controlled medication inventory system, current inventory to the controlled medication declining inventory record and to the resident's MAR, and unused controlled substances held in storage awaiting destruction with the declining inventory record. (continued on next page)

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Many	The facility policy for Routine Reconciliation of Controlled Substances (5.5) identified the facility should routinely reconcile controlled substances stored in medication carts and emergency supplies and should reconcile controlled substances waiting to be destroyed. The policy indicated that the reconciliation should be performed by two licensed nurses or a licensed nurse and authorized and licensed healthcare professional, or per applicable law and the frequency of the reconciliation is determined by the Director of Nursing. The policy identified that a routine reconciliation of controlled substances should compare the total number of doses originally dispensed by the pharmacy to the number of doses remaining to the number of doses recorded as remaining on the medication-specific declining inventory sheet to the number of doses administered according to the resident's medication administration record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility policy/procedures and interviews regarding medication storage, the facility failed to ensure expired medication was disposed of and failed to ensure a medication cart was locked when not in use. The findings include: a. Observation on [DATE] at 10:16 AM with Licensed Practical Nurse (LPN) #2 of the Cedar East medication room identified 2 central line dressing change kits expired [DATE] intravenous (IV) start kits with Chloraprep (these were not patient specific) expired [DATE] and 3 IV start kits for residents who were no longer at the facility expired [DATE]. Interview on [DATE] at 10:18 AM with LPN#2 identified the nursing supervisor was responsible for rotating the stock in the medication rooms. LPN #2 indicated that staff should check the expiration dates prior to using the items and that there were no residents on her unit that required or had an IV that required a dressing change. Interview on [DATE] at 2:04 PM with Registered Nurse (RN) #2 who was the RN nursing supervisor identified all staff were responsible for discarding expired items from the medication room and that the supervisors oversee the medication rooms. Interview on [DATE] at 1:00 PM with the DNS identified all staff were responsible for discarding expired items. Additionally, the DNS noted that facility staff did not start IV's but were responsible to complete dressing changes. Furthermore, the DNS indicated there was only 1 resident who had a Peripherally Inserted Central Catheter (PICC) line and would currently require a dressing change but did not reside on the unit with the expired items. b. Observation on [DATE] at 1:27 PM identified LPN #3 walk away from the Elm unit medication cart, left the cart unlocked with the keys dangling in the lock mechanism. The medication cart was located at the nurses' station as LPN #3 walked 40 feet down the hallway and entered a resident room out of view of the medication cart. During this time, 2 residents and 3 staff members passed by the unsecured cart. Interview on [DATE] at 1:34 PM with LPN #3 identified the facility policy was to lock the cart and take the key if you were leaving the cart. Additionally, LPN #3 indicated that she sometimes leaves the keys in the lock if she was not going to be away from the medication cart for a long time. Interview on [DATE] at 2:04 PM with Registered Nurse (RN) #2 who was the RN nursing supervisor identified the expectation was that the medication carts remained secured when not in use and when out of sight of the nurses. Interview on [DATE] at 1:00 PM with the DNS identified that nurses should maintain possession of the medication cart keys and the carts should not be left unattended unsecured. (continued on next page)

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	03/24/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for Administering and storage of medications identified compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use.