

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER Ludlowe Center for Health & Rehabilitation, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Jefferson Street Fairfield, CT 06825	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491</p> <p>Based on review of clinical records, facility documentation, and interviews, for one (1) of three (3) residents reviewed for incontinent care, (Resident #2), the facility failed to ensure incontinent care was provided timely after resident request. The findings included:</p> <p>Resident #2 had diagnoses of hemiplegia, and muscle weakness.</p> <p>Review of the Admission Minimum Data Set assessment dated [DATE] identified Resident #2 as cognitively intact, was occasionally incontinent of bladder and continent of bowel, and was dependent with toileting and personal hygiene.</p> <p>Review of the Resident Care Plan dated 4/26/24 identified a deficit in self-care, a deficit in functional mobility, and had functional bowel and bladder incontinence related to impaired mobility with interventions that directed assist of one with toilet use, and to check four times a shift and change as required for incontinence.</p> <p>Review of the facility reportable event Form dated 5/13/24 identified NA#1 had gone into Resident #2's room between 4:30 AM and 5:00 AM to check on Resident #2 and was informed he/she needed to be given incontinent care. NA#1 had indicated she would return to change the resident but needed to respond to other call bell lights and forgot to return to Resident #2 to provide incontinent care. Resident #2 had to wait until the first shift nurse's aide arrived before receiving incontinent care, two and a half (2.5) hours after requesting to be provided with incontinent care.</p> <p>Interview with Resident #2 on 5/30/24 at 2:10 PM identified he/she had requested incontinent care near the end of the 11:00 PM to 7:00 AM shift on 5/13/24 as h/her brief was soiled, and he/she did not receive the incontinent care he/she requested until the 7:00 AM to 3:30 PM shift NA came to his room.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NA#1 on 5/30/24 at 1:38 PM identified he/she worked the passport unit on 5/13/24 on the 11:00 PM to 7:00 AM shift and had checked on Resident #2 several times during the early morning hours of 5/13/24 and during his/her last check, between 4:30 PM and 5:00 AM, Resident #2 had requested incontinent care. NA #1 had acknowledged Resident #2's request, however, informed Resident #2 that he/she needed to check on other residents and would return to provide his/her incontinent care. NA #1 further identified that he/she became busy responding to the call lights and providing care for other residents and had forgotten to return to Resident #2 to provide incontinent care, because she was the only NA assigned to the passport unit on the 11:00 PM to 7:00 AM shift. NA#1 further identified that NA#3 was supposed to come from another unit and assist with care, however, he/she never came to assist her on the Passport unit.</p> <p>Interview with LPN #1 on 5/30/24 at 4:30 PM identified he/she was unaware of NA#1 needing additional assistance during the 11:00 PM to 7:00 AM shift on 5/13/24, and had not been asked to assist NA#1 with Resident #2. LPN #1 further identified the passport unit to was short staffed from 11:00 AM to 7:00 PM as NA #1 was the only NA assigned to the floor on 5/13/24.</p> <p>Interview with NA#3 on 6/10/24 at 12:02 PM identified he/she was not asked to assist with care on the passport unit on 5/13/24 for the 11:00 PM to 7:00 AM shift, she remained on the 3 rd floor for her entire shift.</p> <p>Interview with NA#4 on 6/10/24 at 12:07 PM identified on 5/13/24, at the start of his/her shift around 7:30 AM, she entered Resident #2's room and Resident #2 requested incontinent care, and Resident #2 identified that h/she had requested incontinent care from the 11:00 PM to 7:00 AM NA, however, after the request the NA did not return to provide care. NA #4 further identified that she provided incontinent care to Resident #2 who was incontinent of loose stool.</p> <p>Attempts to reach the 11:00 PM to 7:00 AM on 5/13/24 were unsuccessful.</p> <p>Interview with the Assistant Director of Nursing Services (ADNS) on 5/30/24 at 4:40 PM identified it was facility practice to attend to the resident's needs promptly when informed incontinent care was needed.</p> <p>Review of the Certified Nurse's Aide Standard of Care Information Sheet directed to provide peri-care after each incontinent episode.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491</p> <p>Based on review of clinical records and interviews for one (1) of three (3) residents reviewed for incontinent care (Resident #2), the facility failed to provide adequate staffing meet the needs of the residents. The findings included:</p> <p>Resident #2 had diagnoses of hemiplegia, muscle weakness.</p> <p>Review of the Admission Minimum Data Set assessment dated [DATE] identified Resident #2 as cognitively intact, was dependent with toileting, was occasionally incontinent of bladder and continent of bowel.</p> <p>Review of the Resident Care Plan dated 4/26/24 identified a deficit in self-care, a deficit in functional mobility, and has functional bowel and bladder incontinence related to impaired mobility with interventions that directed an assist of one with toilet use, and to check four times a shift and change as required for incontinence.</p> <p>Review of the Reportable Event Form dated 5/13/24 identified NA#1 had gone into Resident #2's room between 4:30 AM and 5:00 AM to check on Resident #2 and was informed he/she needed to be changed (given incontinent care). NA#1 had indicated she would return to change the resident but needed to respond to other call bell lights that had gone off and forgot to return to Resident #2 to provide incontinent care. Resident #2 had to wait until the first shift nurse's aide arrived before receiving incontinent care, two to two and a half hours after requesting to be changed.</p> <p>Interview with NA#1 on 5/30/24 at 1:38 PM identified he/she worked the passport unit on 5/13/24 on the 11:00 PM to 7:00 AM shift and had checked on Resident #2 several times during the early morning hours of 5/13/24 and during his/her last check, between 4:30 PM and 5:00 AM, Resident #2 had requested incontinent care. NA #1 had acknowledged Resident #2's request, however, informed Resident #2 that he/she needed to check on other residents and would return to provide his/her incontinent care. NA #1 further identified that he/she became busy responding to the call lights and providing care for other residents and had forgotten to return to Resident #2 to provide incontinent care, because she was the only NA assigned to the passport unit on the 11:00 PM to 7:00 AM shift. NA#1 further identified that NA#3 was supposed to come from another unit and assist with care, however, he/she never came to assist her on the Passport unit.</p> <p>Interview with LPN #1 on 5/30/24 at 4:30 PM identified he/she was the charge nurse on the passport unit on 5/13/24 for thee 11:00 PM to 7:00 AM shift. LPN #1 identified that she was unaware of NA#1 needing additional assistance on 5/13/24 and had not been asked to assist NA#1 with Resident #2. LPN #1 further identified that the unit was short staffed from 11:00 AM to 7:00 PM as NA #3, who was assigned to split her shift and work half of her shift on the third floor and the other half of the shift on the passport unit, had not come to the passport unit to assist NA #1.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Scheduler on 5/30/24 at 3:15 PM identified that the usual staffing pattern on the passport unit for the 11:00 PM to 7:00 AM shift is 2 NA's and one licensed nurse. On 5/12/24 into 5/13/24 LPN #1, NA #1, and NA #2 were scheduled to work the 11:00 PM to 7:00 AM shift on the Passport wing however, NA#2 had called out. The Scheduler had further indicated the census on the Passport wing on 5/12 into 5/13/24 was 25 and that he/she covered the call out by splitting NA #3's hours, NA#3 (who was originally scheduled to work 11:00 PM to 7:00 AM on the third floor on 5/12/24) would spend half of her shift on the third floor and the second half of her shift on the Passport unit.</p> <p>Interview with NA#3 on 6/10/24 at 12:02 PM identified he/she was not asked to split her 11:00 PM to 7:00 AM shift on 5/12/24 and only worked on the third floor that night.</p> <p>Interview with the Assistant Director of Nursing Services (ADNS) on 5/30/24 at 4:40 PM identified it was facility practice to attend to the resident's needs promptly when informed incontinent care was needed.</p> <p>Attempts to reach the 11:00 PM to 7:00 AM on 5/13/24 were unsuccessful.</p> <p>Review of the Certified Nurse's Aide Standard of Care Information Sheet directed to provide peri-care after each incontinent episode.</p>