STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075330	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ludlowe Center for Health & Rehabilitation	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of two residents (Resident #1), reviewed for a change in condition, the facility failed to ensure the nursing assistant notified the nurse timely of a change in condition. The findings include: Resident #1 was admitted with diagnoses that included chronic kidney disease, heart failure and dementia. A resident care plan (RCP) dated 12/13/2024 had fluid deficit due to diuretic use and increased caloric demand. Interventions directed to monitor vital signs. A 5-day admission minimum data set (MDS) dated [DATE] identified Resident #1 had severe cognitive impairment (BIMS 3), and was dependent for ADLs. Record review identified the following blood pressures: 12/29/2024 at 2:59 PM was 158/67. 12/29/2024 at 5:50 PM was138/66. 12/30/2024 at 12:18 AM was 124/63. 12/30/2024 at 8:55 PM was 101/69. 12/31/2024 at 8:13 AM was 158/50. 12/31/2024 at 5:15 PM was 135/67. 1/1/2025 at 12:34 AM was 94/53. 1/1/205 at 9:46 AM was 76/33. Additional record review failed to identify the charge nurse was notified of the low blood pressure reading of 76/33 at 9:46 AM. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with LPN #3 on 2/25/2025 at 2:10 PM identified she was assigned to Resident #1 on 1/1/2025 on the day shift (7 AM to 3 PM) and she was not aware of the 9:46 AM BP reading. She identified a NA had taken the vital signs and must not have told her of Resident #1's 9:46 AM BP of 76/33. If the NA had informed her then she would have notified the supervisor and documented an evaluation in Resident #1's medical record. LPN #3 stated she only checked the vital sign readings in the Electronic Medical Record (EMR) if there was a medication that directed specific vital signs parameters for administration, and Resident #1 did not have a scheduled medication that would have required her to check the recorded vital signs. Interview with RN #2 on 2/25/2025 at 2:04 PM identified she was the supervisor during 7 AM to 3 PM on 1/1/2025. RN #2 stated she was not notified of any change in condition for Resident #1 during her shift and she did not know why she was not notified of the low blood pressure of 76/33. She continued that she had made frequent rounds and if had she been told of Resident 1's BP reading, she would have rechecked it manually, completed an assessment then notified the on call APRN. She did not know why LPN #3 did not notify her. Interview with NA #1 was not obtained during the survey. Interview and record review with APRN #2 on 2/25/2025 at 1:08 PM identified on 1/1/2025 Resident #1's blood pressure (BP) was documented as 94/53 at 12:34 AM and 76/33 at 9:46 AM. APRN #2 stated the blood pressure of 94/53 could have been a one time reading, but when the next reading at 9:46 AM 76/33, she should have been notified. APRN #2 stated she would have expected to be notified, or the on-call provider be notified as the low blood pressures of 94/53 and 76/33 were a significant change in condition, and she would have requested additional information to determine any change to the treatment plan. Interview and record review with the DON on 2/25/2025 at 1:41 PM identified she would have expected LPN #3 (nurse on 1/1/2025 on the day shift) to notify the supervisor (RN #2) of Resident #1's recorded blood pressure at 9:46 AM of 76/33 as it was a significant change of condition. The DON stated an RN assessment should have been completed and the APRN should have been notified. The vital signs facility practice was for NAs to obtain vital signs, and to document them in the EMR, or give them to the nurse. The DON stated the nurse was responsible for reviewing the vital signs and determining any next steps needed. The DON stated she did not know why LPN #3 did not notify RN #2 of Resident #1's low BP of 76/33 or why an evaluation was not completed. The facility policy Change of Condition Notification, dated 10/17/2023, directed in part, staff should notify the licensed nurse of an identified change of condition and the licensed nurse will complete a physical and mental evaluation. documenting in the medical record.