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	10/06/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**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 #3) reviewed for accidents, the facility failed to develop and implement a comprehensive a comprehensive care plan was implemented with person-centered interventions for a resident with known grabbing behaviors. The findings include: Based on review of the clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #3) reviewed for accidents, the facility failed to develop and implement a comprehensive comprehensive care plan was implemented with person-centered interventions for a resident with known grabbing behaviors. The findings include: Resident #3 had diagnoses that included dementia with behavioral disturbance, anxiety, depression, reduced mobility, and generalized muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15) indicative of severely impaired cognition, exhibited physical and verbal behavioral symptoms directed toward others, was dependent on staff for all ADLs, including bed mobility and transfers, was non-ambulatory and was dependent for wheelchair mobility. The Resident Care Plan (RCP) dated 7/10/2025 identified Resident #3 had a potential for altered mood and behavior due to dementia, had the potential to be physically and verbally aggressive and had repeated movements that included hitting, kicking, pushing, grabbing, pinching, biting, and threatening behaviors, yelled/screamed, and used abusive language. Interventions directed to monitor behaviors, and to intervene before agitation escalates, guide away from source of distress, engage calmy in conversation, if response is aggressive, directed staff to walk away calmly and reapproach later. A physician order dated 8/13/2025 directed side rails: half rails up to enable bed mobility every shift. Review of Resident #3's side rail evaluation dated 8/27/2024 identified Resident #3 had a self-care deficit, and side rails were used as an enabler to promote independence. The side rail evaluation directed the use of half (1/2) rails/mobility bars for assistance with bed mobility, not to exceed 28 inches in length from the head of the bed. Review of the task/monitor behavior symptoms sheets identified from 9/9 to 9/23/2025, Resident #3 exhibited grabbing behaviors daily except on 9/14 and 9/15/2025. Facility reportable event dated 9/23/2025 at 11:00 A.M. identified Resident #3 had a history of striking and hitting behaviors, and presented with right hand edema, discomfort, and erythema (redness). Resident #3 was unable to explain what occurred. X-ray results identified an acute nondisplaced fracture of the proximal phalanx (finger bone closest to the palm) of the fifth digit (finger). APRN #4's note dated 9/23/2025 identified Resident #3 was seen for reported bruising and swelling of the right outer hand. A STAT (immediate) x-ray identified an acute nondisplaced fracture in the proximal phalanx of the fifth digit of the right hand. Review of the facility summary dated 9/26/2025 identified Resident #3 had grabbing behaviors with care and during transfers, and extends his/her right arm with the hand lying in between the lower bar openings of the siderail. The summary identified the discoloration noted on the right hand aligns with the siderail. The summary further indicated the fracture was sustained when Resident #3 placed his/her hand in the lower open portion of the siderail. The summary indicated the siderails were discontinued and a perimeter (raised edge) mattress was placed on the bed. Review of facility investigation identified the following staff statements: LPN #8's written statement dated 9/24/2025 identified Resident #3 had grabbing behaviors. NA #10's written statement dated 9/25/2025 identified Resident #3 had sudden movements and grabbing behaviors, and during Hoyer lift transfers, Resident #3 always swings his/her arms and grabs. Further, NA #10 indicated she uses a pillow to position Resident #3's arms during Hoyer lift transfers and Resident #3 also grabs at the pillow. Interview with NA #11 on 10/6/2025 at 9:18 A.M. identified Resident #3 always grabs the side rails. Further, NA #11 stated before she provides care to Resident #3, she places a pillow between Resident #3 and the siderails to prevent Resident #3 from grabbing hold of the siderails. Interview and review of NA written statement with NA #8 on 10/3/2025 at 9:41 A.M. identified during care Resident #3 grabs the siderails. Interview, record review and written statement review with RN #3 on 10/3/2025 at 10:48 A.M. identified at times Resident #3 was resistant to care and would grab the siderails on the bed. Interview and written statement review with NA #7 on 10/3/2025 at 11:07 A.M. identified Resident #3 always grabbed and attempted to grab the side rails or Hoyer lift during care. Interview, record review and review of written statement with LPN #7 on 10/3/2025 at 11:11 A.M. identified she was aware Resident #3 had a history of being resistive to care and grabbing the siderails. Interview with NA #3 on 10/3/2025 at 11:22 A.M. identified Resident #3 always grabs the side rails

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**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 #3) reviewed for accidents, the facility failed to ensure a resident with known grabbing behaviors was free from injury related to side rail use. The findings include:Resident #3 had diagnoses that included dementia with behavioral disturbance, anxiety, depression, reduced mobility, and generalized muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had Brief Interview for Mental Status (BIMS) score of one (1) out of fifteen (15) indicative of severely impaired cognition, exhibited physical and verbal behavioral symptoms directed toward others, was dependent on staff for all ADLs, including bed mobility and transfers, was non-ambulatory and was dependent for wheelchair mobility. The Resident Care Plan (RCP) dated 7/10/2025 identified Resident #3 had a potential for altered mood and behavior due to dementia, had the potential to be physically and verbally aggressive and had repeated movements that included hitting, kicking, pushing, grabbing, pinching, biting, and threatening behaviors, yelled/screamed, and used abusive language. Interventions directed to monitor behaviors, and to intervene before agitation escalates, guide away from source of distress, engage calmy in conversation, if response is aggressive, directed staff to walk away calmly and reapproach later. Review of Resident #3's side rail evaluation dated 8/27/2024 identified Resident #3 had a self-care deficit, and side rails were used to promote independence. The side rail evaluation directed the use of half (1/2) rails/mobility bars for assistance with bed mobility, not to exceed 28 inches in length from the head of the bed. A physician order dated 8/13/2025 directed side rails: half rails up to enable bed mobility every shift. Review of the task/monitor behavior symptoms sheets identified from 9/9/2025 to 9/23/2025, Resident #3 exhibited grabbing behaviors daily except on 9/14/2025 and 9/15/2025. Facility reportable event dated 9/23/2025 at 11:00 A.M. identified Resident #3 presented with right hand edema, discomfort, and erythema (redness). Resident #3 was unable to explain what occurred. X-ray results identified an acute nondisplaced fracture of the proximal phalanx (finger bone closest to the palm) of the fifth digit (finger). APRN #4's note dated 9/23/2025 identified Resident #3 was seen for reported bruising and swelling of the right outer hand. Resident #3 was unable to provide information regarding the injury due to cognitive impairment. A STAT (immediate) x-ray identified an acute nondisplaced fracture in the proximal phalanx of the fifth digit of the right hand. Review of the facility summary dated 9/26/2025 identified Resident #3 had grabbing behaviors with care and during transfers, and extends his/her right arm with the hand lying in between the lower bar openings of the side rail. The summary identified the discoloration noted on the right hand aligns with the side rail. The summary further indicated the fracture was sustained when Resident #3 placed his/her hand in the lower open portion of the side rail. The summary indicated the side rails were discontinued and a perimeter (raised edge) mattress was placed on the bed. Interview with NA #11 on 10/6/2025 at 9:18 A.M. identified she last provided care for Resident #3 on 9/20/2025, and when providing care, Resident #3 always grabs the side rails. Further, NA #11 stated before she provides care to Resident #3, she places a pillow between Resident #3 and the side rails to prevent Resident #3 from grabbing hold of the side rails. Interview and written statement review with NA #7 on 10/3/2025 at 11:07 A.M. identified Resident #3 always grabbed and attempted to grab the side rails or Hoyer lift during care. NA #7 stated she provided care and transferred Resident #3 on 9/22/2025 during the 7 A.M. to 3 P.M. shift, and Resident #3 was yelling and reaching out during care and Hoyer transfer, and she redirected Resident #3 and folded Resident #3's arms onto his/her lap during the transfer. Interview and review of NA written statement with NA #8 on 10/3/2025 at 9:41 A.M. identified she provided care for Resident #3 on 9/22/2025 during the 3 to 11 P.M. shift. NA #8 stated Resident #3 required assistance of one with bed mobility, and during care Resident #3 grabs the side rails. NA #8 further stated when providing care on 9/22/2025, Resident #3 got his/her right hand stuck in between the upper and lower bars on the side rails, and she did not notify the nurse because he/she always grabs the side rail and gets his/her right hand intertwined between the railing. Interview with NA #3 on 10/3/2025 at 11:22 A.M. identified she provided care on the morning of 9/23/2025, and her shift ended at 7 A.M. NA #3 stated Resident #3 always grabs the side rails during care and before she provides care to Resident #3, she places a pillow between Resident #3 and the side rails to prevent Resident #3 from getting injured. NA #3 stated she did not observe any injury, redness or swelling on the right hand during her shift. Interview, record review and review of written statement with LPN #7 on 10/3/2025 at 11:11 A.M. identified she last provided care for Resident #3