

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/21/2026
NAME OF PROVIDER OR SUPPLIER Ludlowe Center for Health & Rehabilitation		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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #2) reviewed for accidents, the facility failed to ensure adequate supervisor for a resident with dementia to prevent leaving the facility without staff knowledge. The findings include: Resident #2 had a diagnosis of history of falls, vascular dementia, auditory hallucinations, and parkinsonism (neurological deficit). The admission Minimum Data Set (MDS) dated [DATE] identified Resident #2 had a Brief Interview Mental Status (BIMS) score of 9 indicating moderately impaired cognition, had no behaviors, and required maximal assistance with transfers. The Resident Care Plan (RCP) dated 12/12/25 identified a self-care deficit, deficit in functional mobility, and potential for falls. Interventions directed to note any changes in gait, assist of one (1) with transfers, and ambulation with rehabilitation department only. Facility Elopement evaluation dated 12/1/25 identified Resident #1 was not a risk for elopement. Nursing note dated 1/11/26 at 2:34 PM identified Resident #2 had left the building at 1:44 PM; Resident #2 told the Receptionist he/she was a visitor and left the building with a walker. Record review failed to identify any exit seeking behaviors since admission on [DATE]. Nursing note dated 1/11/26 at 6:11 PM identified she observed Resident #2 seated in a chair and calm in his/her room at approximately 12:03 PM. Facility Reportable Event (RE) dated 1/16/26 identified on 1/11/26 Resident #2 was observed leaving the facility at 12:45 PM and at 1:40 PM a neighbor notified the facility that Resident #2 was home. Upon notification, the nursing supervisor checked the unit and confirmed that Resident #2 was not in the facility, and notified the attending physician, and the local police department and requested a wellness check. The local police department conducted a wellness check and reported back to the facility that Resident #2 was home and safe with his/her live-in caregiver. Facility RE summary dated 1/16/25 identified the wellness check identified Resident #2 was safe and did not want to return. The police reported Resident #2 walked to a nearby church where he/she was a member and obtained a ride home from a church member. The facility confirmed Resident #2 had the necessary medications and supplies to meet his/her needs. The facility identified Resident #2 was last observed by staff at approximately 12 PM during lunch, and was wearing jeans, turtleneck and sweatshirt, and appeared calm with no expressed desire to leave. Facility surveillance footage showed Resident #2 left the building at 12:17 PM through the atrium door (opened the door him/herself). The receptionist got up from the desk and looked out the window, and exited the facility to approach Resident #2. Facility interview identified the receptionist asked Resident #2 if he/she was okay and if he/she was a resident. Resident #2 responded he/she was okay and stated he/she was not a resident, was only visiting. Resident #2 proceeded to walk down the driveway to the sidewalk and toward the traffic light and the receptionist returned to the building. Facility interviews identified the receptionist did not observe any nametag or (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075330 If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	markings on the walker. Review of facility camera footage revealed the following timeline: Resident #2 entered the elevator at approximately 12:15 PM. Resident #2 entered the lobby through the atrium door at approximately 12:17 PM. The atrium door was equipped with a locking mechanism requiring simultaneous activation of a wall-mounted button and door handle; video indicated Resident #2 successfully opened the door after three attempts. Resident #2 exited the front door at approximately 12:19 PM. The receptionist got up from the desk and looked out the window with visual on the resident and at approximately 12:21 PM the receptionist exited the facility to approach the resident. Facility written statement from Receptionist #1 dated 1/11/26 identified she was sitting at the front desk when she observed an older person with a light blue sweater walk past the reception desk with a walker. Receptionist #1 stood up to see where he/she was going and thought they were waiting for a ride because a car had pulled up to the front door. the person did not get in the car and turned left and started walking on the sidewalk toward the street. Receptionist #1 then went out the front door and approached him/her and asked if they were okay, and the person stated yes. Receptionist #1 asked if he/she was a resident and he/she stated no, and that they came to visit. Receptionist #1 then asked if he/she knew where they were going and the person said yes, for a walk. Receptionist #1 noted there was no identification wrist band on and then the person turned left out of the driveway of the facility toward the traffic light (on the sidewalk) and continued walking. Interview with the Director of Rehabilitation on 7/21/26 at 11:23 AM identified Resident #1 ambulation and transfer status was with a walker and supervision. The Director of Rehabilitation further stated although Resident #2 should not transfer or ambulate without supervision, it would be possible for Resident #2 to transfer and ambulate off the unit without supervision. Interview with the Director of Nursing (DNS) and Administrator on 7/21/26 at 1:26 PM identified the Receptionist #1 did not tell staff about the person she observed outside because she thought the person was a visitor and she did not observe any ID bracelet on the person, so she did not think to tell anyone else. However, facility upon investigation identified that Resident #1 did have their identification bracelet on during medication pass on 1/11/26 and that Resident #2 may have taken it off at some point before exiting the facility. Resident #2 had no prior exit seeking behaviors, and was not an elopement or wander risk. Interview failed to identify why staff did not notice Resident #2 walking to the elevator and exiting the unit, and why Resident #2 was able to exit the facility without staff knowledge. Review of facility Elopement Policy dated December 2025 directed that an elopement was defined as the unauthorized absence of a resident from the facility who was unable to make decisions due to mental capacity. Facility documentation review identified staff education was initiated on 1/11/2026 and included review of the elopement policy, and the facility conducted elopement drills starting on 1/15/26. A QAPI meeting was held on 1/11/26 and 1/13/26. Based on review of facility documentation, past non-compliance was identified.		