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	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ludlowe Center for Health & Rehabilitation	118 Jefferson Street Fairfield, CT 06825

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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	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 review of the clinical record, facility documentation, facility policy, and interview, for the resident (Resident #12) reviewed for accidents, the facility failed to provide adequate supervision for a resident at risk to fall, who was placed in a common area to be closely watched and fell, sustaining an acute fracture at the base of the femoral neck. Additionally, the facility failed to maintain supervision during shift changes, ensure staff assignment/accountability, timely identify and report significant changes in condition, and implement care plan interventions.The findings include:Resident #12's diagnosis included Alzheimer's Disease and dementia. The care plan dated 05/2/2025 indicated Resident #12 was at risk for falls due to poor communication/comprehension, impaired mobility, impaired cognition, resistance to care and the use of psychiatric and cardiac medications. Interventions included to provide non-skid footwear when ambulating or mobilizing in the wheelchair, encourage Resident #12 to be out of the bedroom when awake for socialization and/or recreational activities, offer diversional activities such as music, snacks, toileting, ambulating, fluids, puzzles, therapy evaluation and treat as indicated and to check the medication regimen with the pharmacist regarding medications that increase risk for falls. The care plan dated 05/05/2025 indicated Resident #12 had a deficit in functional mobility with interventions including 2-person assistance for transfers and bed mobility and ambulation only with the rehab/therapy department. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #12 was severely cognitively impaired, used a walker and a wheelchair, required maximum assistance for sit to stand and transfers, was dependent on staff for ambulating 10 feet and had no signs of pain. The MDS further indicated Resident #12 had no falls in the last 6 months prior to admission, had no falls since admission to the facility and was receiving physical and occupational therapy. A nursing note dated 05/09/2025 at 4:23 AM indicated Resident #12 was resistive with hands-on care, confused and had no complaints of pain. An SBAR Summary (standard format for organizing and conveying information) dated 05/09/2025 completed by the charge nurse (LPN #5) at 11:00 PM indicated Resident #12 had a fall which occurred at the change of shift resulting in a skin tear and no evidence of pain. The Reportable Event Form completed by LPN #5 dated 05/09/2025 indicated Resident #12 had an unwitnessed fall at 10:57 PM while in the dining room and sustained a skin tear to the right elbow. Resident #12 was alert, restless, agitated and confused at times, had poor safety awareness and made several attempts to ambulate unassisted. Resident #12 required assistance of 2 for transfer and bed mobility, assist of 1 person for activities of daily living and ambulates only with therapy. Further, no change in mental status or physical status was noted except for a skin tear of the right elbow for which treatment was provided. The APRN and family member was notified. Range of motion (ROM) was within normal limits, no internal or external rotation of limb per the Registered Nurse The form was signed by the Administrator dated 05/20/2025. A Nursing Pain Tool evaluation dated 05/09/2025 at 11:00 PM indicated Resident #12 had no pain at the present time or during the last 5 days. An order note dated effective 05/10/2025 at 2:02 AM written by the second shift Nursing Supervisor, (RN #5), indicated on 05/09/2025 at 10:57 PM Resident #12 was sitting in the dining room in a wheelchair, stood up and was on the floor with a (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	skin tear on the right outer elbow. The APRN was notified and a treatment order for the elbow skin tear was obtained at 11:16 PM. After a body audit was conducted, including range of motion (ROM) and neurological checks Resident #12 required 3 staff members to stand and transfer to the wheelchair. The resident representative was notified of the incident by the charge nurse at 11:16 PM. A Change in Condition (CIC) follow-up note dated 05/10/2025 at 07:02 AM by the 11:00 PM - 7:00 AM charge nurse (LPN #4) indicated Resident #12 had no complaints of pain or distress, neurological evaluation continues in progress with no attempts to get out of bed and slept well. A Medication Administration Note dated 05/10/2025 at 08:04 PM indicated Tylenol 325mg, 3 tablets were given to Resident #12 orally for moderate pain. Tylenol was effective with no pain on reevaluation. A late entry note for 05/10/2025 at 08:04 PM indicated LPN #4 was present with nurse aide NA #8 providing incontinent care. Resident #12 was at his/her baseline confusion with pushing staff away with his/her hands and kicking both legs while in bed. Resident #12 indicated his/her leg hurts. LPN #4 indicated Resident #12 was independently, actively, moving both legs up and down without difficulty, noting no observable abnormalities including changes in skin color, bruising, redness or swelling. Tylenol was given for stated leg pain with positive effect, and the resident was observed in bed resting and slept the remainder of the shift. A Physical Therapy Treatment Encounter Note dated 05/11/2025 at 11:17 AM indicated Resident #12 had dementia and was a fall risk. The note indicated Standing at the Rolling walker 2 times for 1 minute and 1 time for 45 seconds was completed with minimum assistance of the therapist. Sit to stand to the rolling walker with minimum to moderate assistance of the therapist and verbal cues for proper sequencing was completed. The note further indicated Resident #12 was resistant to therapy saying, I can't and refused walking. A Change in Condition Follow-Up Note dated 05/11/2025 at 06:02 PM indicated no changes in range of motion or immobility. A Change in Condition Follow-up Note dated 05/12/2025 at 07:37 AM indicated in Resident #12 was post fall day #3 with a skin tear to the right elbow, no signs or symptoms of pain, agitation noted only when providing care and slept well. A Health Status Note Dated 05/12/2025 at 12:15 PM written by RN #6 indicated she notified the APRN that Resident #12 had right leg pain and would not allow her to touch the leg to assess. A late entry note dated 05/12/2025 at 3:11 PM by RN #6 indicated she was notified by the nurse aide that Resident #12 had right leg pain and on assessment of the right leg and hip Resident #12 flinched. The APRN was notified. A Progress Note Dated 05/12/2025 at 1:42 PM written by APRN #1 indicated the reason for the visit to Resident #12 was for complaints of right leg/hip pain. The assessment identified Resident #12 was complaining of right leg pain (s/p fall 05/09/2025, 3 days ago) but due to dementia was unable to articulate the exact location of the pain but pain was noted to the right hip on palpation and the resident had difficulty lifting the right lower extremity. As a result, x-rays to rule out a fracture and Tylenol 1000mg orally 3 times a day for pain control was ordered. A Health Status Note dated 05/13/2025 at 11:49AM indicated the x-ray provider called to report Resident #12 had an acute right hip fracture. The nursing supervisor and APRN were updated and orders were obtained to send Resident #12 to the hospital emergency room for further evaluation. After the responsible family member was notified, the resident was transferred to the hospital via ambulance leaving the facility at 11:50 AM. A reportable event form, event first known to the facility dated 05/13/2025 at 12:00 PM resulted in a serious injury. It further indicated Resident #12 had an unwitnessed fall on 05/09/2025 at 11:00 PM and on 05/12/2025 Resident #12 was noted to be guarding the right lower extremity and complaining of leg pain. Subsequently Resident #12 was evaluated by APRN #1 and scheduled Tylenol for pain was ordered along with x-rays. The x-rays indicated an acute nondisplaced fracture at the base of the femoral neck (hip fracture) and Resident #12 was transferred to the hospital. A statement from LPN #5, who worked on 5/9/2025, dated 05/15/2025 (6 days after the fall) indicated she was monitoring Resident #12 and other residents in the common area and when the oncoming shift nurse arrived LPN #5 left to complete the narcotic count. LPN #5 indicated she did not see the resident fall but found the resident on their right side on the floor complaining of pain to the right elbow where a skin tear was noted. A (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	facility interview with LPN #4 completed during their investigation dated 05/15/2025 (6 days after the fall) indicated on 05/10/2025 s/he assisted NA #8 to provide incontinent care as the nurse aide indicated the resident was being combative with care. During care Resident #12 complained of right leg pain and remembering the fall on 05/09/2025, LPN #5 administered Tylenol for the pain and upon reevaluation the resident indicated no further pain. The Reportable Event Summary dated 05/19/2025 indicated during Resident #12's hospitalization the resident underwent open reduction and internal fixation (ORIF) surgery to repair the right hip fracture and was readmitted to the facility on [DATE].An interview, facility document and clinical record review with RN #3, the regional RN, on 09/12/2025 at 10:45 AM indicated upon further investigation after the fracture was discovered, s/he noted on 05/10/2025 at 08:04 PM, Resident #12 had complained of right leg pain, the nurse administered Tylenol but did not report the pain to the supervisor or the physician. RN #3 identified staff had moved Resident #12 to the dining room for falls with other residents at risk to be closely watched, but at the change of shift no one was watching Resident #12 while the charge nurses were counting the narcotics. RN #3 stated the facility does not provide 1:1 supervision. Interview with the Director of Nursing Services (DNS) on 09/15/2025 at 01:50 PM indicated on 9/16/2025 at 11:05 AM interview with LPN #5 (charge nurse for Resident #12 at the time of the fall on 05/09/2025) indicated Resident #12 had already been toileted and provided care, was sitting close to the nurse's station in the dining room. LPN #5 indicated residents who were seated in the dining room are those who are restless or cannot sleep and are brought to the dining room so staff can keep an eye on them. The nurse aides are assigned a half hour at a time during the shift. LPN #5 indicated she was not aware of which staff member was scheduled to watch Resident #12 at the change of shift when the fall occurred. LPN #5 indicated she did not tell the nurse aides to be sure someone was watching the residents in the dining room while the two charge nurses were counting the narcotic medications. LPN #5 indicated other staff were at the nursing station due to change of shift but could not remember who. LPN #5 indicated NA #12 had most likely left the unit before 11:00 PM to report to another unit s/he was scheduled to start working at 11:00 PM stating the nurse aides give each other report at the change of shift and if they are leaving the unit they report to staff before doing so. An interview with RN #5 on 09/16/2025 at 11:38 AM who worked as the 3:00 PM - 11:00 PM nursing supervisor on 05/09/2025 indicated s/he was called to the unit due to a resident fall. After assessing Resident #12's range of motion, there were no leg length changes, no external rotation, no pain or abnormalities. There was a skin tear on the elbow. The on-call APRN service was called, the fall and resident condition was reported, a treatment order obtained, and the charge nurse called the family member. An interview on 09/16/2025 at 11:58 AM with NA #10 who worked the 3:00 PM - 11:00 PM shift on 5/9/2025 indicated s/he was coming back from a resident room and when passing the dining room was asked by the nurses to come help them as Resident #12 was on the floor. NA #10 indicated there were assignments indicating who and when each staff member was assigned to watch the residents in the dining room area further indicting not knowing who was assigned and added it was the change of shift, and everyone was getting ready to leave. An interview on 09/16/2025 at 12:16 PM with LPN #4 who worked second shift (3:00 PM - 11:00 PM) on 5/10/2025 and first and second shifts (7:00 AM - 3:00 PM and 3:00 PM- 11:00 PM) on 05/11/2025 indicated the nurse aide asked him/her to assist with Resident #12 due to the resident being combative while trying to provide incontinent care. While assisting NA #8 with providing care to Resident #12, NA #8 indicated to LPN #4 that Resident #12 was having leg pain. LPN #4 indicated Tylenol was given for pain and was effective later when the resident was reevaluated and the resident slept the remainder of the shift. LPN #8 indicated the 3:00 PM - 11:00 PM supervisor did not come to the unit to obtain report at the end of the shift and LPN #8 indicated she did not call the supervisor to report the pain because it was relieved with the Tylenol provided. Further, the resident was moving his/her legs and was not screaming in pain and the supervisor would only be notified when the pain medication does not work. LPN #4 who worked the next day (5/11/2025) indicated Resident #12 was already up in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wheelchair when seen and had no complaints of pain or discomfort and had visitors who stayed for quite some time and offered no concerns. Attempts were made on 09/16/2025 at 12:48 PM to contact NA #8, the third nurse aide who worked 05/09/2025 3:00 PM - 11:00PM (second shift) and worked second shift on 05/10/2025 who provided incontinent care to Resident #12 and reported Resident #12 had complained of leg pain, were unsuccessful. An interview on 09/16/2025 at 01:02 PM with RN #6 who worked first shift on 05/12/2025 indicated noticing Resident #12 had pain and flinched when touched and notified the APRN who was in the facility and ordered x rays.An interview on 9/17/2025 at 7:23 AM with NA #12 who worked 5/9/25 second shift (3:00 PM -11:00 PM) and was assigned to provide care for Resident #12 indicated Resident #12 was always on the move further indicating care and toileting had been provided around 09:45 PM then the resident was brought to the dining room/lounge area to be watched. NA #12 identified Resident #12 cannot be placed in bed until later when the resident shows signs of being tired because he/she would try to get out of bed unassisted and could fall. NA #12 indicated not knowing who was assigned to watch the residents in the dining room/lounge area at the time. NA #12 left the unit at about 10:53 PM to report for duty for the 3rd shift on another unit at the facility. NA #12 further indicated about 10 minutes after leaving the unit, a nurse aide came to find her on the new assigned unit to provide an investigation statement to be completed by NA #12 as Resident #12 had a fall. NA#12 indicated not being able to remember where the staff were on the unit when s/he reported to them s/he was leaving the unit for the next shift but did indicate staff would have been at the nurse's station or the Kiosk at the end of the shift preparing to leave. The facility policy Labeled Fall Prevention Program indicated that all residents would be evaluated for risk for falls on admission, readmission, and with a change of condition. Residents at high risk for falls would have interventions initiated to prevent falls.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy and interview for 1 of 4 residents (Resident #98) reviewed for respiratory care, the facility failed to determine if it was clinically appropriate for the resident to self-administered oxygen. The findings include:Resident #98 was admitted to the facility in April 2025 with diagnoses that included atherosclerotic heart disease (plaque buildup inside the arteries that supply blood to the heart), chronic kidney disease, and heart failure.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #98 was cognitively intact and required moderate assistance (helper does less than half the effort) with toileting hygiene, showering, upper and lower body dressing, and transfers. The Resident Care Plan (RCP) dated 7/31/25 identified Resident #98 had altered respiratory status, difficulty breathing and hypoxemia (low levels of oxygen in the blood). Interventions included position resident with proper body alignment for optimal breathing and administer oxygen 2 at liters per minute via nasal cannula.Observations on 9/8/25 at 12:41 PM and at 2:20 PM identified Resident #98 seated in wheelchair inside in his/her room with oxygen at 2 liters via nasal cannula. Observation on 9/9/25 at 11:30 AM identified Resident #98 seated up in bed with oxygen at 2 liters via nasal cannula. Interview with LPN #1 on 9/10/25 at 10:02 AM identified Resident #98 puts the oxygen on when he/she feels short of breath and the physician is not aware.Interview with Assistant Director of Nurses (ADNS) on 9/10/25 at 10:39 AM identified if Resident #98 puts oxygen on when he/she feels short of breath, there should be a physician's order for it and Resident #98 should be evaluated to ensure he/she is able to self-administer oxygen.Interview with the Director of Nurses on 9/15/25 at 9:23 AM identified that an evaluation is needed to determine the resident's ability to safely self-administer oxygen.Review of the Self-Administration Policy dated 10/2024 directed a Self-Administration Evaluation is completed by the licensed nurse to evaluate the resident's safety and understanding of their medication/treatments. If evaluation determines it is safe for the resident to self-administer, the licensed nurse will obtain an order from the Healthcare Provider for self- administration for the specific medication/treatment. The licensed nurse is responsible to account for every medication/treatment on the EMAR and TAR. The licensed nurse will periodically review for continued cognitive and physical ability to self-administer.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for the only resident (Resident #44), reviewed for missing clothing, the facility failed to acknowledge the resident's complaint of missing clothing and actively work toward resolution of that complaint. The findings include: Resident #44 was admitted with diagnoses that included chronic pain. The quarterly MDS dated [DATE] identified Resident #44 was cognitively intact. The MDS further indicated that Resident #44 required set-up or clean-up assistance for upper-body dressing and supervision or touching assistance for lower-body dressing. A care plan dated 7/11/2025 indicated that Resident #44 had a self-care deficit with interventions that included to provide supervision, such as verbal cues or touch assist for dressing. Interview with Resident #44 on 9/8/2025 at 12:44 PM identified that he/she was missing 2 to 3 pairs of pants, 2 shirts, and a sweater that had been taken to the laundry 3 weeks ago. Resident #44 indicated he/she was particularly concerned about the sweater, as it was a sweater he/she frequently used to go to appointments in the mornings. Resident #44 indicated he/she had told NA #7 and Laundry Aide #1, but could not recall the date. Resident #44 could not recall if his/her clothes were labelled. Further, Resident #44 indicated he/she did not know if anything was being done about the missing clothes and that, since the incident, he/she has family do the laundry. A review of nursing notes from 8/25/2025 to 9/10/2025 and review of social work documentation from 1/24/2025 to 9/15/2025 failed to identify documentation related to missing belongings. A review of the clical record failed to identify a Personal Belongings Checklist. Interview with NA #7 on 9/10/2025 at 10:58 AM identified that laundry was usually placed in personal laundry hampers that are labelled with the resident's room and bed number. The laundry department collects the hampers and returns the clothes a few days later. NA #7 indicated that Resident #44 had told her, a while back, that he/she was missing clothes from the laundry. Further, NA #7 indicated she had found a pajama suit belonging to Resident #44 in another resident's room and returned it to Resident #44. NA #7 identified that Laundry Aide #1 and LPN #1 were aware of the missing belongings. Interview with LPN #1 on 9/10/2025 at 12:00 PM identified that she was aware that Resident #44 was missing clothes and further indicated that laundry was aware, however, LPN #1 could not identify what had been done or what was being done regarding the missing clothes. Additionally, a record review with LPN #1 failed to identify a Personal Belongings Checklist in the paper chart or the electronic medical record. Interview with the Director of Housekeeping on 9/10/2025 at 1:32 PM, who also oversaw the laundry department indicated that laundry that was collected on Tuesdays and Wednesdays was returned the following Monday, and laundry collected on Saturday and Sunday was returned on the following Thursday. The Director of Housekeeping indicated it's a [NAME] turnaround time for personal laundry to be returned from the day it was collected to the day it gets dropped off the by the laundry aide. The Director of Housekeeping indicated that the facility has a tracking system for missing belongings, and when belongings are missing, the facility tells the resident to give the facility a few weeks to look for the belongings. The Director of Laundry indicated he was not aware of any missing belongings for Resident #44. Interview with Social Worker #1 on 9/10/2025 at 2:31 PM indicated she was not aware Resident #44 had any missing belongings. Social Worker #1 indicated that when clothing is reported missing to social services, they work with the laundry department, notify the family or resident of what is being done, and then do a last follow-up once missing belongings are resolved or are unable to be resolved. Social Worker #1 indicated that social services gets notified of missing belongings by residents, family, or the nurse aides. Additionally, nurse aides, family, or residents can fill out a grievance form. Once social services receives the grievance, the social worker will follow up with the resident to obtain a list of belongings that are missing. Interview with the Director of Housekeeping on 9/10/2025 at 3:22 PM identified there was no other tracking (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system for missing belongings and that he used the grievance forms to track missing belongings. Additionally, the Director of Housekeeping indicated that he did not think Resident #44's clothes were labelled; however, the Director of Housekeeping further indicated that whether clothes are labelled or not, the facility would still follow the grievance process. The Director of Housekeeping indicated that Resident#44 must have been overlooked, and therefore, there was no grievance written for regarding the missing laundry, and that he had spoken to Resident #44 on 9/10/2025 to obtain details of the missing clothing. Interview with Laundry Aide #1 on 9/10/2025 at 3:25 PM identified that she was aware of Resident #44's missing belongings and that the resident had been complaining to her about missing laundry for a while but could not recall the exact dates but indicated the resident complained to her about the same belongings 3 or 4 times. Laundry Aide #1 indicated that once Resident #44 was crying about his/her missing sweater, which had a hood. Laundry Aide #1 indicated she went through the clothes in the laundry room but was unable to locate any, and that she told the Director of Housekeeping of Resident #44's missing laundry on several occasions but was unaware of what had been done. The facility policy for Resident Lost Property indicated that upon report by a resident of lost property, the facility would document the report as a grievance pursuant to the facility's Grievance Policy and conduct a thorough search for the missing property. The facility's Grievance Policy indicated that facility staff are encouraged to attempt to resolve the verbal grievance/concern at the time it is brought forward, when possible, and that in the case that a concern cannot be resolved promptly, the staff member would complete the grievance form or give it to the person with the concern to complete. The form would then be forwarded to the social service department.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record and interviews for 1 of 2 residents (Resident #154) reviewed for discharge, the facility failed to ensure complete information regarding the discharge was documented in the resident's medical record and complete information was communicated to the receiving health care institution or provider. The findings include:Resident #154's diagnosis included pneumonia and dysphagia.The care plan dated 07/3/2025 indicated Resident #154 was in need of a safe and appropriate discharge plan with interventions including to assess discharge needs, at admission and throughout stay, involve the resident, family, and/or responsible party in discharge planning, providing education, regarding medications and/or treatments and therapy home evaluations if needed.The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #154 had a moderate cognitive impairment.A Discharge Summary Guide-V4 dated 07/25/2025 at 1:35 PM was incomplete with sections not completed by nursing, physical/occupational/speech therapy, and dietary. The social service section indicated Resident #154 was to receive home care services and would have a private duty nurse aide. The form indicated oxygen, and a transport chair were ordered through a supplier and indicated the need to follow up with the primary physician for an appointment. The retained discharge information also include an 8-page form labeled NAC: Functional Abilities Summary-discharge and NPE-V5 (an assessment of Resident #154's functional abilities during the last 3 days of his/her stay at the facility), functional status was blank on the first 7 1/2 pages, and there was no staff signature.An interview with the DNS on 09/15/2025 at 1:10 PM indicated she was not able to locate the W-10 or a physician order for discharge home with services.An interview and record review on 09/15/2025 at 2:05 PM with SW #2 identified the interdisciplinary discharge summary was not completed or signed by the complete interdisciplinary team and no physician order was found. The W-10 would have been completed by nursing, and SW #2 would obtain a copy to fax to the home care agency and nursing would retain a copy for the chart. SW #2 indicated s/he only retains the W-10 faxed to the agencies for about 2 weeks then discards and does not retain a copy of fax receipt.The facility policy labeled Clinical Services Subject: Admission, Discharge Policy section, Discharge Process indicated in part, the interdisciplinary team would complete all necessary discharge paperwork including the Discharge Summary guide, the Transfer/Discharge Report the forms are then placed in the discharge folder and given to the resident or the responsible party at the time of discharge. The policy further indicated the licensed nurse would be responsible for reviewing the Discharge Summary guide and the transfer/discharge report including the me with the resident/responsible party and once completed the patient/responsible party signs the form and the health care provider signs the document then uploads the document into the electronic health care record.

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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	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** Based on observation, review of the clinical record, facility documentation, and interviews for 1 of 2 residents (Resident #102) reviewed for indwelling catheter, the facility failed to develop a care plan with interventions to care for the catheter and for 1 resident (Resident #13) reviewed for skin, the facility failed to ensure the care plan was updated to include noncompliance with geri sleeves. The findings include: Resident #102‘s diagnoses included retention of urine. A physician's order dated 7/31/25 directed to irrigate the indwelling catheter with 60cc of sterile saline. The admission Minimum Data Set assessment dated [DATE] identified Resident #102 was cognitively intact, dependent with toilet hygiene and max assistance with bed mobility. The care plan dated 8/7/25 failed to reflect the indwelling catheter. Interview with Resident #102 on 09/08/2025 at 12:07 PM indicated ongoing pain due to catheter. The resident indicated he/she has reported the pain to staff; however, they have not been able to give him/her an answer. Interview with the DNS on 9/15/2025 at 10:32 AM indicated that a care plan should identify focus areas and the nursing team is responsible for ensuring this is done. The DNS is unsure why the care plan was not updated to reflect residents' indwelling catheter. The policy Baseline/Comprehensive Person-Centered Care plan indicates the Comprehensive Person-Centered Care plan will be kept current by all disciplines on an ongoing basis. Disciplines will be responsible for updating the care plan. 2. Resident #13 was admitted on [DATE] with diagnoses that included dementia, diabetes, and nonthrombocytopenic purpura (small purple or red spots on the skin from bleeding under the skin). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was severely cognitively impaired and required moderate assistance (helper does less than half the effort) with toileting hygiene, upper and lower body dressing, personal hygiene and maximal assistance (helper does more than half the effort) with transfers. The Resident Care Plan (RCP) dated 8/7/25 identified Resident #13 had potential for skin breakdown due to muscle weakness. Interventions included to perform skin checks with care for changes, report changes to the nurse and treatments as ordered. A physician's order dated 8/17/25 directed bilateral upper extremity (both arms) geri sleeves (soft fabric sleeves used to protect skin) every shift for fragile skin related to nonthrombocytopenic purpura. Check placement every shift. May remove for care. Observations on 9/8/25 at 1:23 PM and on 9/15/25 at 9:56 AM identified Resident #13 dressed in long (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleeve top without the benefit of geri sleeves. Interview with LPN #2 on 9/15/25 at 9:58 AM identified Resident #13 refused to wear geri sleeves on both upper arms, did not currently have them on, has a history of skin tears to both arms and is non-complaint with the geri sleeves. Interview with Assistant Director of Nurses (ADNS) on 9/15/25 at 10:13 AM identified if Resident #13 refused to wear geri sleeves, staff should re-approach Resident #13 to wear them and if refused, family and physician should be notified, and a care plan should be developed to address the noncompliance. Subsequent to surveyor inquiry, on 9/15/25 the RCP was revised with interventions that included to apply house moisturizer to both upper arms and long sleeve shirts and long sleeve sweaters to be placed. Although requested, a facility policy for skin protective devices was not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interview for the only resident (Resident #12) reviewed for accidents the facility failed to ensure staff transferred the resident with the assistance of 2 per the plan of care, and for 1 resident (Resident #13) reviewed for skin, the facility failed to ensure geri sleeves were applied per the physician's order. The findings include: Resident #12's diagnosis included Alzheimer's Disease. The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #12 was severely cognitively impaired, used a walker and a wheelchair, required maximum assistance for transferring from sitting to a standing position and for transfers to a chair, and had no signs or symptoms of pain. The care plan dated 05/5/2025 indicated Resident #12 had a deficit in functional mobility with interventions that included the need for the assistance of 2 staff members for transfers and bed mobility. The Reportable Event Form completed by LPN #5 dated 05/09/2025 indicated Resident #12 had an unwitnessed fall on 05/09/2025 at 10:57 PM and sustained a skin tear to the right elbow. The resident was alert, restless, agitated and confused at times, had poor safety awareness and several attempts to ambulate unassisted. Resident #12 required assistance of 2 for transfer. A facility Investigation Statement form (no date) indicated NA #9 had worked 3rd shift (11:00 PM - 07:00 AM) on Resident #12's unit and assisted Resident #12 back to bed around 11:20 PM after the resident sustained a fall with injury at the change of shift. NA #9 indicated she transferred Resident #12 from the wheelchair to the bed alone without a second staff member by standing the resident who then turned and sat on the side of the bed. NA #9 further indicated Resident #12 had no complaints of pain at that time, was in bed the remainder of the shift and had no complaints of pain. An interview and clinical record review with RN #3 indicated after further investigation once the fracture was known, a nurse aide identified she had independently transferred Resident #12 to bed after the fall but should have transferred Resident #12 with 2 staff members assistance per the plan of care. An interview on 09/12/2025 at 01:48 PM with NA#9 who worked 3rd shift (11:00 PM - 07:00 AM) identified she assisted Resident #12 back to bed from the wheelchair alone without another staff assist. NA #9 did not offer a reason why she did not ask for another staff member to assist with the transfer as Resident #12's care plan indicated 2 staff assistance. A policy regarding resident transfers was not provided. The Facility policy labeled Change in Condition Notification indicated in part the purpose of the policy is to ensure a resident's change of condition is evaluated, documented, and reported to the healthcare provider. 2. Resident #13 was admitted on [DATE] with diagnoses that included dementia, diabetes, and nonthrombocytopenic purpura (small purple or red spots on the skin from bleeding under the skin). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was severely cognitively impaired and required moderate assistance (helper does less than half the effort) with toileting hygiene, upper and lower body dressing, personal hygiene and maximal assistance (helper does more than half the effort) with transfers. The Resident Care Plan (RCP) dated 8/7/25 identified Resident #13 had potential for skin breakdown due to muscle weakness. Interventions included to perform skin checks with care for changes, report changes to the nurse and treatments as ordered. A physician's order dated 8/17/25 directed bilateral upper extremity (both arms) geri sleeves (soft fabric sleeves used to protect skin) every shift for fragile skin related to nonthrombocytopenic purpura. Check placement every shift. May remove for care. Observations on 9/8/25 at 1:23 PM and on 9/15/25 at 9:56 AM identified Resident #13 dressed in long sleeve top without the benefit of geri sleeves. Interview with LPN #2 on 9/15/25 at 9:58 AM identified Resident #13 refused to wear geri sleeves on both upper arms, did not currently have them on, has a history of skin tears to both arms and is non-complaint with the geri sleeves. Interview with Assistant Director of Nurses (ADNS) on 9/15/25 at 10:13 AM identified if Resident #13 refused to wear geri sleeves, staff should re-approach Resident #13 to wear them and if refused, family and physician should be notified, and a care plan should be developed to address the noncompliance. Interview with ADNS on 9/15/25 at 11:45 AM identified the physician's order for application of geri sleeves daily should be followed, and if Resident #13 is non-compliant, the physician should be notified. Although requested, a facility policy for skin protective devices was not provided.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 4 residents (Resident #98) reviewed for respiratory care, the facility failed to obtain a physician's order for oxygen for a resident who was using oxygen as needed and failed to ensure the oxygen tubing was dated when changed. The findings include: Resident #98 was admitted to the facility on [DATE] with diagnoses that included atherosclerotic heart disease (plaque build up inside the arteries that supply blood to the heart), chronic kidney disease, and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #98 was cognitively intact and required moderate assistance (helper does less than half the effort) with toileting hygiene, showering, upper and lower body dressing, and transfers. The Resident Care Plan (RCP) dated 5/16/25 identified Resident #98 had altered respiratory status and difficulty breathing with hypoxemia (low levels of oxygen in the blood). Interventions included to position the resident with proper body alignment for optimal breathing and administer oxygen 2 liters per minute via nasal cannula. Observation on 9/8/25 at 12:41 PM and at 2:20 PM identified Resident #98 seated in wheelchair with oxygen at 2 liters via nasal cannula. The oxygen tubing was not dated when last changed. Observation on 9/9/25 at 11:30 AM identified Resident #98 seated up in bed with oxygen 2 L on via nasal cannula with no date label on oxygen tubing.Interview with LPN #1 on 9/9/25 at 11:46 AM identified Resident #98 is on oxygen, and the oxygen tubing should be changed and dated on Sundays. Further LPN #1 had not noticed that the oxygen tubing was not dated. Interview with Director of Nurses (DNS) on 9/9/25 at 2:18 PM identified oxygen tubing should be changed and dated weekly. Further if oxygen tubing is not dated, tubing should be changed, and a date label placed on by the nurse. Interview with LPN #1 on 9/10/25 at 10:02 AM identified Resident #98 did not have a physician's order for oxygen however, Resident #98 puts on the oxygen when he/she feels short of breath. Interview with Assistant Director of Nurses (ADNS) on 9/10/25 at 10:39 AM identified if Resident #98 placed oxygen on via nasal, there should be a physician's order. Review of the vitals summary on 9/10/25 at 12:30 PM identified Resident #98 received oxygen via nasal cannula on 7/10/25, 7/11/25, 7/12/25, 7/13/25, 7/14/25, 7/19/25, 8/5/25, 8/15/25, and 9/1/25.Subsequent to surveyor inquiry, a physician's order dated 9/10/25 directed to administer oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath, and oxygen saturation below 90% on room air.A physician's order dated 9/12/25 directed to change oxygen tubing weekly every night shift on Sundays Review of the Oxygen Therapy policy directed physician's orders for oxygen should include the liter flow, type of oxygen, and delivery device and to change all disposable equipment weekly.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 5 residents (Resident #4) reviewed for unnecessary medications, the facility failed to address pharmacy recommendations in a timely manner. The findings include: Resident #4 was admitted [DATE] with diagnoses included chronic respiratory failure with hypercapnia (too much carbon dioxide in blood), dependence on ventilator (a machine that helps person breathe), anxiety disorder, major depressive disorder, and gastrostomy (a small opening made in the stomach to put in a tube so person can get food and medicine). The RCP dated 4/28/24 identified Resident #4 had a nutrition diagnosis of swallowing difficulty. Interventions included to administer enteral nutrition (a method of providing nutritional support directly into the gastrointestinal tract through a tube) and flushes per Medical Doctor orders.A Pharmacy Consultant Drug Regimen Review dated 3/20/25 identified the resident with a as needed (prn) order for milk of magnesia to be administered by mouth. Noted to have most medications administered via feeding tube. Please consider updating route of administration, if appropriate. The form was not signed.Physician's order dated 5/14/25 directed to administer milk of magnesia suspension 400 milligrams (MG)/5 milliliters (ML), give 30 ML by mouth as needed for constipation daily. A physician's order dated 5/15/25 directed to administer protonix oral packet 40 MG, give 1 packet by mouth one time a day for gastroesophageal reflux and administer lorazepam tablet 0.5 MG, give 1 tablet by mouth every 8 hours as needed for anxiety.A Pharmacy Consultant Drug Regimen Review form dated 5/15/25 identified the recommendation; Resident with a standing order for pantoprazole and PRN orders for lorazepam and milk of magnesia to be administered by mouth. Noted to have most medications administered via G tube. Please consider updating route of administration, if appropriate. The form was dated 9/14/25.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was cognitively intact and required the assistance of 2 or more helpers with eating, oral hygiene, personal hygiene, dressing, and transfers. Further, Resident #4 had a feeding tube. The Resident Care Plan (RCP) dated 7/17/25 identified Resident #4 used psychotropic medications due to depression, and anxiety. Intervention included to administer psychotropic medications as ordered by physician and pharmacy review per protocol and as needed. A physician's order dated 8/18/25 directed to administer milk of magnesia suspension 400 MG/5 ML, give 30 ML via G-tube (feeding tube that goes directly into the stomach through the belly) as needed for constipation daily.Physician's order dated 9/10/25 directed to administer lorazepam tablet 0.5 MG, give 1 tablet via G tube every 8 hours as needed for anxiety for 14 days. Physician's order dated 9/14/25 directed to administer protonix oral packet 40 MG, give 1 packet via G-tube one time a day for GERD. Interview with the Director of Nurses (DNS) on 9/15/25 at 10:53 AM identified that pharmacy recommendations are emailed in a report to the DNS and Assistant Director of Nurses (ADNS) and the report is printed out and given to the unit managers. The unit managers then give it to the physician to review. Further, a pharmacy recommendation made in March 2025 should be addressed sooner than in August 2025, and a pharmacy recommendation made in May 2025 should be addressed sooner than in September 2025. Interview with the ADNS on 9/15/25 at 11:10 AM identified that pharmacy recommendations are emailed in a report to the ADNS and the DNS and they distribute that report to the unit managers to review with the Advanced Nurse Practitioner (APRN) to evaluate, sign and date the recommendation when reviewed. Further, the APRN would review the recommendations within a week of the report being received, and the previous DNS wanted to take responsibility for this process. Review of the Pharmacy Medication Review/Consultant Pharmacist Recommendations Policy revised 04/2023 directed findings and recommendations are communicated to those with responsibility to implement the recommendations, and to answer in a timely fashion.