STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

Facility DBA and Address
Ludlowe Center for Health & Rehabilitation
118 Jefferson Street Fairfield CT
M: 06825

Signature of FLIS Staff J. Ellington, Cesar Castillo, [signature], [signature]

Survey Team Leader: Jordanne Ellington
Supervisor: Sandra Vermont Hollis

Licensure Category: ~~Select~~ CCNH
License Number: ________
Licensed Bed Capacity: 144
Licensed Bassinet Capacity: ___
Census: 131

Date(s) of onsite inspection: 9/8/25, 9/9/25, 9/10/25, 9/12/25 & 9/15/25

Date(s) additional information obtained: ____________________

Personnel contacted: Patricia Page Administrator & Barbara Stuart regional DNS

Email Address: ppage@nathealthcare.com & bstuart@nathealthcare.com

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

- [x] Licensing Inspection ☐ *Initial* ☑ *Renewal* ☐ *Other (e.g.strikes)*: ___________
- [ ] Visit **OR** Revisit for the purpose of ____________________
- [x] See Complaint Investigation # 120671 (J.E), 120675 (C.C)
- [ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated ____________
- [ ] Desk Audit ____________ ☐ Amended Letter: ____________ Original Ltr.__________
- [ ] Citation # ____________ was issued to this facility as a result of this inspection.
- [ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.
- [ ] Citation # ____________ was/was not verified as corrected. See attached narrative report.
- [ ] Narrative report/additional information attached.
- [ ] See Certification File.
- [ ] Referral(s) to ____________________

REPORT SUBMITTED BY: Jordanne Ellington LMSW DATE OF REPORT: 9/16/2025

- [ ] Approval for issuance of license granted by: ____________________ DATE: ____________

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

SURVEY TEAM WILL COMPLETE:

Standard Survey:		Extended Survey:	
From: F1 *(mm/dd/yyyy)*	To: F2 *(mm/dd/yyyy)*	From: F3 *(mm/dd/yyyy)*	To: F4 *(mm/dd/yyyy)*
09/08/2025	9/15/2025		

GENERAL INSTRUCTIONS:

This form is to be completed by the Facility. For the purpose of this form, "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Name of Facility	Provider Number	F5: Fiscal Year Ending *(mm/dd/yyyy)*
Ludlowe Center for Health & Rehabilitation	075330	09/30/2025

Street Address: 118 Jefferson ST

City	County	State	Zip Code
Fairfield	Fairfield	CT	06825

F6: Telephone Number:	F7: State/County Code:	F8: State/Region Code:
203.372.4501		

F8a: Medicare	F8b: Medicaid	F8c: Other	F8d: Total Residents
31	63 + 6 pending	3	131

F9: 01

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

F10: Is this facility hospital based? ..... ○ Yes ◉ No

If yes, indicate Hospital Provider Number: F11

F12: Ownership: 13

For-Profit	Non-Profit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

F13: Owned or leased by Multi-Facility Organization ..... ◉ Yes ○ No

F14: Name of Multi-Facility Organization: National Healthcare Association

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15: AIDS	F16: Alzheimer's Disease	F17: Dialysis
000	000	000
F18: Disabled Children/Young Adults	**F19: Head Trauma**	**F20: Hospice**
000	000	000
F21: Huntington's Disease	**F22: Ventilator/Respiratory Care**	**F23: Other Specialized Rehabilitation**
000	010	40 dementia

F24: Does the facility currently have an organized residents' group? ..... ◉ Yes ○ No

F25: Does the facility currently have an organized group of family members of residents? ..... ○ Yes ◉ No

F26: Does the facility conduct experimental research? ..... ○ Yes ◉ No

F27: Is the facility part of a continuing care retirement community (CCRC)? ..... ○ Yes ◉ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:		**Waiver of 24 hr licensed nursing requirement:**	
F28: Date *(mm/dd/yyyy)*	F29: Hours waived per week:	F30: Date *(mm/dd/yyyy)*	F31: Hours waived per week

F32: Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? ..... ○ Yes ◉ No

Name of Person Completing Form Patricia Page Patricia Page	Time 11:30 AM
Signature	Date 9/8/2025

TO BE COMPLETED BY SURVEY TEAM:

1. Was ombudsman office notified prior to survey? ..... ☑ Yes ○ No

2. Was ombudsman present during any portion of the survey? ..... ○ Yes ☑ No

3. Medication error rate 0 % (The medication error rate at the time of survey, based upon observation by the surveyor. This is a percentage. You can enter only whole numbers up to 999.)