STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075355	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stone Bridge Center for Health & Rehabilitation	139 Toddy Hill Road Newtown, CT 06470

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy/procedures and interviews for the one sampled resident (Resident #103) reviewed for abuse, the failed to ensure the resident was free from mistreatment sustained from a resident-to-resident altercation. The findings include: Resident #103 was admitted to the facility March 2025. Diagnoses included left knee effusion, muscle weakness, dementia, anxiety and difficulty walking. The admission MDS assessment dated [DATE] identified Resident #103 had severe cognitive impairment, had behaviors that were not directed at others, displayed wandering behaviors, required moderate to total dependence with activities of daily living, did not ambulate and utilized a wheelchair. Physician's orders dated 3/5/25 directed administration of anti-depressant medications and monitoring of side effects and behavior of sadness. The care plan dated 3/11/25 identified Resident #103 had a deficit in functional mobility and was non-ambulatory with use of a wheelchair. The care plan additionally identified Resident #103 had some agitation with long term care placement with an intervention that included safely housed on designated unit. A reportable event report dated 3/19/25 at 4:10 PM identified Resident #103 was seated in a wheelchair in his/her room when Resident #112 entered the room and sat in a chair. Resident #103 identified that he/she asked the him/her to leave and then Resident #112 stood up and went over to Resident #103 and slapped him/her in the face. The report further identified that Resident #103 was assessed and did not sustain any injuries from the altercation. A DNS note dated 3/19/25 at 6:00 PM identified the same incident as stated in the reportable event report and noted Resident #103 felt safe and requested the room door be closed. A nursing progress note dated 3/20/25 at 3:51 PM identified a stop sign was placed in the doorway of Resident #103's doorway but was refused by Resident #103. A social service progress note dated 3/21/25 at 11:10 AM identified the social worker met with Resident #113 as a follow up to the incident with another resident and had no signs of distress. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #112 was admitted to the facility 10/21/24 with a diagnosis of Alzheimer's disease with mood disturbance. Nursing progress note dated 10/22/24 at 8:56 AM identified Resident #112 wandering into other residents' rooms most of the night and noted Resident #112 was redirected and did not change behaviors and was very easily agitated. Nursing progress note dated 10/24/24 at 12:20 PM identified Resident #112 hit a nurse aid (NA) at the nurse's station, unprovoked. The note indicated Resident#112 punched her left arm and back, took the computer desk and tried to throw it at her. Resident #112 called the NA a vulgar name and was medicated for agitation. Nursing progress note dated 10/28/24 at 7:56 AM identified Resident #112 was trying to enter other resident's rooms and got agitated and verbally abusive when staff tried to interfere. Nursing progress note dated 10/28/24 at 3:46 PM identified Resident #112 continued to wander into other resident's room and refused care. Nursing progress note dated 11/24/24 at 8:18 AM identified Resident #112 was anxious and restless last night and walking in and out of other resident's room, became agitated when staff tried to redirect, and was medicated with Trazodone and slept from 3-7am. Nursing progress note dated 12/3/24 at 9:10 AM identified Resident #112 was awake most of the night and walking in hallway trying to enter other residents' rooms. Nursing progress note dated 1/4/25 at 7:12 AM identified Resident #112 wandered all night and sat in chairs on different units to nap and would become agitated when redirected by staff. The significant change MDS assessment dated [DATE] identified Resident #112 had severely impaired cognition, exhibited physical and verbal behaviors directed toward others, including rejection of care, wandering, and was independent with ambulation. The assessment further identified that behaviors triggered as a focus area to be care planned for and the indication on the assessment was that it would be included on the care plan. The care plan dated 2/21/25 identified Resident #112 was dependent on staff for meeting emotional, intellectual and social needs related to cognitive deficits with interventions that included: allow resident to explore the environment in a safe manner, introduce to other residents with similar backgrounds, interests, and encourage/facilitate interaction, offer a quiet place if overstimulated during activities. The care plan further identified Resident #112 had the potential to be verbally/physically aggressive related to dementia, mental/emotional illness/psychosis. Interventions included: monitor behaviors every shift, staff to remain near the resident while on one-to-one observation but allow a small amount of space to avoid triggering negative behaviors and intervene before agitation escalates; guide away from source of distress and if response is aggressive, staff to walk calmly away and approach later. The care plan did not address the resident's behavior of wandering. The nursing note dated 3/10/25 at 6:02 PM identified Resident #112 was positive for influenza A and was resistive to wearing mask or face guard. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing note dated 3/11/25 at 8:17 AM identified Resident #112 was placed on droplet precautions but continued to ambulate in the hallway and became agitated when staff tried to encourage mask. The nursing note dated 3/11/25 at 6:05 PM identified Resident #112 had difficulty with remaining in room due to significant confusion and behaviors. The care plan (revision) dated 3/14/25 identified Resident #112 wanders all over the nursing unit and in and out of other resident's rooms. Care plan interventions included distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, and identify patterns of wandering. The care plan further identified the resident had impaired cognitive function with an intervention of 1 to 1 monitoring due to aggression with residents which was added on 3/19/25. The nursing progress note dated 3/19/25 at 5:24 PM identified Resident #112 wandered into the other resident room and when asked to leave, hit the other resident (Resident#103) in the face on the left side with an open hand. The note indicated Resident#112 was immediately placed on 1 to 1 monitoring and was sent to the acute care emergency department for evaluation. Nursing progress note dated 2/8/25 at 10:47 PM identified refusals of care and verbally swearing and aggressive to staff. The nursing note dated 3/19/25 at 5:24 PM identified Resident #112 wandered into Resident #103's room and when asked to leave, hit Resident#103 in the face on the left side with an open hand. The note further indicated Resident #112 was placed on immediate 1 to 1 monitoring, the APRN was notified, and Resident #112 was sent to the acute care hospital emergency department to be evaluated. Interview on 5/28/25 at 10:25 AM with LPN#5 identified staff sometimes call Resident #112's family member who is sometimes able to assist with redirection. LPN#5 indicated Resident #112 refuses medications, changes and treatments. LPN#5 identified that when Resident #112 does not get medicated due to refusals, it effects the resident's behaviors on the following shifts. Interview on 6/2/25 at 1:27 PM with the Regional Director of Nursing Services identified the facility does not complete A and Is for residents who assault/hit staff members unless the staff member was injured and required treatment. Facility policy for abuse identified that each resident has the right to be free from abuse.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy/procedures and interviews for one sampled resident (Resident #112) with behaviors, the facility failed to ensure the care plan was comprehensive in addressing the resident's behavior of wandering into other residents' rooms, although the behavior was identified on the admission MDS and behaviors triggered, and it was noted that behaviors would be included on the comprehensive care plan. The findings include: Resident #112 was admitted to the facility 10/21/24 with a diagnosis of Alzheimer's disease with mood disturbance. Nursing progress note dated 10/22/24 at 8:56 AM identified Resident #112 wandering into other residents' rooms most of the night and noted Resident #112 was redirected and did not change behaviors and was very easily agitated. Nursing progress note dated 10/24/24 at 12:20 PM identified Resident #112 hit a nurse aid (NA) at the nurse's station, unprovoked. The note indicated Resident#112 punched her left arm and back, took the computer desk and tried to throw it at her. Resident #112 called the NA a vulgar name and was medicated for agitation. Nursing progress note dated 10/28/24 at 7:56 AM identified Resident #112 was trying to enter other resident's rooms and got agitated and verbally abusive when staff tried to interfere. Nursing progress note dated 10/28/24 at 3:46 PM identified Resident #112 continued to wander into other resident's room and refused care. The admission MDS assessment dated [DATE] identified the resident had severely impaired cognition, behaviors that included physical and verbal abuse, and wandering that does not significantly intrude on the privacy activities of others, had no range of motion impairments and was independent with ambulation. The assessment further identified the resident triggered for behavioral symptoms with the decision made to include on the comprehensive care plan. The comprehensive care plan dated 11/1/24 did not identify the resident's behavior of wandering or contain interventions that addressed the resident's wandering behaviors specifically the behavior of wandering into other residents' rooms. Nursing progress note dated 11/24/24 at 8:18 AM identified Resident #112 was anxious and restless last night and walking in and out of other resident's room, became agitated when staff tried to redirect, and was medicated with Trazodone and slept from 3-7am. Nursing progress note dated 12/3/24 at 9:10 AM identified Resident #112 was awake most of the night and walking in hallway trying to enter other residents' rooms. Nursing progress note dated 1/4/25 at 7:12 AM identified Resident #112 wandered all night and sat in chairs on different units to nap and would become agitated when redirected by staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The significant change MDS assessment dated [DATE] identified Resident #112 had severely impaired cognition, exhibited physical and verbal behaviors directed toward others, including rejection of care, wandering, and was independent with ambulation. The assessment further identified that behaviors triggered as a focus area to be care planned for and the indication on the assessment was that it would be included on the care plan. The care plan dated 2/21/25 identified Resident #112 was dependent on staff for meeting emotional, intellectual and social needs related to cognitive deficits with interventions that included: allow resident to explore the environment in a safe manner, introduce to other residents with similar backgrounds, interests, and encourage/facilitate interaction, offer a quiet place if overstimulated during activities. The care plan further identified Resident #112 had the potential to be verbally/physically aggressive related to dementia, mental/emotional illness/psychosis. Interventions included: monitor behaviors every shift, staff to remain near the resident while on one-to-one observation but allow a small amount of space to avoid triggering negative behaviors and intervene before agitation escalates; guide away from source of distress and if response is aggressive, staff to walk calmly away and approach later. The care plan did not address the resident's behavior of wandering. Interview on 5/28/25 at 10:38 AM with LPN #5 identified that the LPNs and nursing supervisors can add problems and interventions to the care plan, she further identified that Resident #112's behavior of wandering into other resident's rooms should have been including on the comprehensive care plan. She noted that the nursing supervisor or the MDS Coordinator should have added it. Additionally, she noted that the staff attempts to redirect Resident #112 when attempts to enter other residents' rooms are made. Interview on 6/2/25 at 11:47 AM with the DNS identified that when Resident #112 is aggressive or wandering into other resident rooms, staff should intervene and redirect, attempt to keep the resident in sight and attempt distant supervision. The DNS indicated Resident #112's wandering into other resident rooms should have been added when the resident was admitted based on the Interview on 6/2/25 at 1:05 PM with the ADNS, who added the care plan intervention of wandering that was dated 3/14/25, identified she could not with 100% certainty explain why the wandering intervention was added at that time, but indicated Resident #112 was wandering in and out of other resident rooms. The baseline/comprehensive person-centered care plan policy identified that the comprehensive person-centered care plan will be periodically reviewed and revised by a team of qualified persons after each assessment or reassessment or episodically as the plan of care changes. The policy indicated that the comprehensive person-centered care plan would be kept current by all disciplines on an ongoing basis and that disciplines would be responsible for updating the care plan when there was a new problem that requires intervention. The facility failed to care plan for Resident #112's behavior of wandering after identifying the behavior on two comprehensive assessments and identify that behaviors would be included on the care plan and although the care plans included some of the behaviors identified on the assessments. They did not address the wandering behavior.

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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 clinical records, review of facility documentation, review of facility policy and interviews for two of four sampled residents (Resident #61 and #228) reviewed for accidents, the facility failed to ensure the wheelchair leg rests were in place during transport, which resulted in an accident and failed to ensure the resident was transferred as ordered with assist of one and the utilization of a walker, which resulted in a right lower leg laceration sustained as a result of the improper transfer from the wheelchair to the bed. The findings include: 1. Resident #61's diagnoses included cerebral infarction, narcolepsy, anemia, peripheral vascular disease, and muscle weakness. The quarterly MDS assessment dated [DATE] identified Resident #61 had intact cognition and was dependent on staff for transfers, was non-ambulatory, and was dependent on staff for wheelchair mobility. The care plan dated 3/4/25 identified Resident #61 had a deficit in functional mobility related to cerebral infarction with left side weakness. Care plan interventions directed to transfer using a mechanical lift, was non-ambulatory and needed extensive assistance with bed mobility. The Situation, Background, Assessment, and Recommendation (SBAR) nurse's note dated 4/25/25 at 1:34 PM identified Resident #61's left leg was caught under the wheelchair while being transported by the Recreation Aide (RA #1) without using the leg rests. The nursing notes also identified Resident #61 had a medical history of cerebral infarction, narcolepsy, and type 2 diabetes mellitus. The assessment did not identify medical condition changes and did not complain of left leg pain. The recommendation was to encourage Resident #61 to use the wheelchair leg rests when being transported in the wheelchair. The facility accident and incident report dated 4/25/25 at 3:15 PM identified RA #1 was transporting Resident #61 in a wheelchair from the activity program to the resident room without the wheelchair leg rests. It also identified Resident #61 was holding both of his/her legs up during the wheelchair transport and his/her left leg lowered and went under the wheelchair. Interview with RA #1 on 5/28/25 at 11:30 AM identified Resident #61 had an accident on 4/25/25 after he/she requested assistance to bring him/her back to his/her room after participating in the activity program. She identified that the accident happened during transporting Resident #61 in the nursing hallway while both legs was elevated and suddenly Resident #61's left leg was caught under the wheelchair. She identified that the wheelchair leg rests were not in use when the accident occurred. She identified that the wheelchair leg rests must be used when staff is transporting a resident in a wheelchair. She further identified that she received education from the facility after the incident to ensure the wheelchair leg rests were in place prior to transporting the resident in a wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the DNS on 5/29/25 at 10:30 AM identified that leg rests should be utilized when the staff is transporting a resident in a wheelchair. She also identified that an accident and/or injury could occur when the wheelchair leg rests are not used during the wheelchair transport. She further identified RA #1 did not use the wheelchair leg rests when she transported Resident #61 in the wheelchair and his/her left leg went under the wheelchair. She further identified that the RA #1 received education after the incident to ensure the leg rests was utilized in a wheelchair during wheelchair transportation. A facility policy for wheelchair transport was requested but a policy was not provided. 2. Resident #228's diagnoses include dementia, atrial fibrillation, anemia and feeding difficulties. The quarterly MDS assessment dated [DATE] identified Resident #228 had severely impaired cognition (BIMS of 3), required maximal assistance with toileting hygiene, upper and lower body dressing, personal hygiene, and transfers, required moderate assistance with bed mobility, did not ambulate and was dependent for wheelchair mobility. The care plan dated 11/8/24 identified Resident #228 had a deficit in self-care function with interventions that included the use of a two wheeled walker (assistive device). Review of the Nurse Aide care card in effect for the month of January 2025 identified Resident #228 required the assistance of one staff for transfers utilizing the rolling walker with wheelchair to follow. The physician's order for the month of January 2025 directed the assistance of one for toileting, transfers, and ambulation utilizing a rolling walker with wheelchair to follow closely. The reportable event report dated 1/10/25 at 7:00 PM identified that during a transfer from the wheelchair to the bed Resident #228 sustained a laceration to the left lower leg. The report noted that NA #1 transferred Resident #228 from the wheelchair to the bed and then noticed blood on the resident's pant leg, and when she pulled up the pant leg, she noticed a laceration to the right lower leg. The report further noted that the charge nurse and nursing supervisor were immediately notified, pressure was applied to the wound, the APRN was notified, and the resident was sent to the acute care hospital emergency department via ambulance. Additionally, the report noted that the wound was not measured at that time due to maintaining pressure to the wound until emergency personnel arrived at the facility. The reportable event report identified a written statement by NA #1 dated 1/10/25 that identified that while transferring Resident #228 from the wheelchair to the bed she noticed a gash on the lower right leg and alerted the charge nurse and the supervisor. The statement further identified that during the transfer the wheelchair was locked in preparation of the transfer. She noted that during the transfer Resident #228 hugged her and they both stood up, turned and sat on the bed. The documentation further noted Resident #228 was calm throughout the transfer and was not resistive during the transfer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the acute care hospital discharge instructions dated 1/11/25 identified Resident #228 was diagnosed with a leg laceration and was given one dose of Keflex 500mg (antibiotic) at 4:00AM on 1/11/25. The wound evaluation dated 1/15/25 identified the laceration to the front right lateral lower leg occurred on 1/10/25, measured 10.3 centimeters (cm) in length and 1.5 cm in width and required 28 staples. The evaluation further noted the wound did not have depth, undermining, or tunnelling noted. Interview with NA #1 on 5/28/25 at 10:22 AM identified Resident #228 was wheeled from the dining room to his/her room in preparation for bed. NA #1 identified Resident #228 was exhausted, soaking wet and was unable to stand independently. She identified that Resident #228 was a stand pivot assist of one staff member utilizing a rolling walker. She further identified that she did not use the rolling walker because the resident was unable to follow her direction. NA #1 was asked if residents were supposed to hug her during a transfer and should gait belts be used during transfers. NA #1 responded that residents should not be hugging her and if there was not a note in her statement regarding the use of a gait belt then she probably had not used the gait belt during the transfer. Additionally, NA #1 identified that she did not ask anyone for assistance with the transfer or notify the charge nurse that the resident appeared exhausted. She noted that because the resident was a stand pivot transfer, and weighed approximately 90 pounds, she felt she could transfer him/her on her own. Interview with the DNS and the Regional Clinical Nurse (RN #1) on 5/28/25 at 12:05 PM identified that the investigation of the incident identified NA#1 did not use the rolling walker during the transfer as required. The DNS noted that the utilization of the walker would have allowed the resident to step out, turn and pivot to avoid his/her leg from rubbing against the prongs connecting the leg rest. The DNS identified after re-enacting the transfer with the resident wearing protective shin sleeves. She further identified that the investigation identified that Resident #228's right leg rubbed against the two metal pieces that stick out to lock the leg rest in place, she noted that blood was observed on the metal prongs. The DNS further noted NA #1 did not use a gait belt and residents should not be hugging the staff during a transfer and when a resident is not able to be transferred as ordered, the charge nurse should be notified, because a resident can be downgraded in transfer status (meaning the resident can be transferred by two if necessary) but they should not be upgraded (meaning transferred not as ordered with assistive devices when that is what is ordered to just doing as was done with Resident #228). She added that education and disciplinary action was taken toward NA #1 regarding this incident and education was provided to NA #1 as well as all staff on transfers as this was a serious injury that had occurred. Interview with the Charge Nurse (LPN #2) on 5/28/25 at 1:32 PM identified she was the nurse on duty when the incident occurred and was notified by NA #1 of the right lower leg laceration. LPN #2 identified Resident #228 was in bed, and the injury looked like it had just happened as the blood was red, did not appear coagulated, and the blood was pooling inside of the wound. The Competency One Assist Transfer Technique skills identified the steps to take when transferring with one assist include: prepare the chair by removing the leg rest and lock the brakes; apply the gait belt on resident and stand in front of the resident with one foot between the resident's feet, the other foot on the outside edge of the resident foot, and then grasp the gait belt on either side and have the resident place his/her hands on your shoulders/upper arm, followed by gently rocking on the count of 3 and stand with resident and sit resident on the bed then remove the gait belt. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Activities of Daily Living (ADL) policy identified that staff provide assistance to complete ADL activities per the person-centered evaluation and care plan such as functional mobility which is the ability to get from place to place while performing ADLs, either under one's own power or with the assistance of a wheelchair or other assistive device.