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	05/21/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policies, and interviews for two of three residents (Resident #2 and #3) reviewed for resident rights, the facility failed to maintain comfortable temperature levels within the range of 71 to 81 degrees Fahrenheit (F). The findings include: 1.Resident #2's diagnoses included dementia, anemia, diabetes mellitus, restlessness-agitation, and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of twelve out of fifteen (12/15), indicative of moderate cognitive impairment and required assistance with ADL's (activities of daily living). The Resident Care Plan (RCP) dated 4/10/26 identified impaired cognitive function/thought process related to dementia. Interventions directed if increased confusion noted, to place resident on UTI (urinary tract infection) monitoring for three days, monitor/document/report as needed any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level ofconsciousness, and mental status. Nursing note dated 4/15/26 at 19:57 (7:57 PM) identified new order to transfer to hospital for stroke-like symptoms. Review of the Emergency Medical Services (EMS) Run Sheet dated 4/15/26 at 6:08 PM identified EMS was called to the facility for Resident #2 who was weak with changes to his/her speech reported by facility staff. Resident #2 usually can ambulate to the bathroom on his/her own, but today was unable to stand on his/her own, speech slower to staff today, beginning one hour prior, and denied pain. the Run Sheet noted it is severely hot on the xxxx floor where Resident #2 resides and his/her skin is dry with tenting and hot to the touch, and EMS transferred Resident #2 to the hospital. Review of the Emergency Department admission Documentation dated 4/15/26 at 8:36 PM identified Resident #2 arrived from the facility for weakness and difficulty walking with left lower extremity weakness and had difficulty following commands. EMS reported that the facility was hot and the thermostat temperature at the facility was 90 degrees Fahrenheit. Over the last few days, the facility did not have any air conditioning and the temperature within the building went up to about 90 F. approximately one (1) and a half hours after Resident #2's arrival at the hospital, he/she was awake, alert, talkative and oriented at baseline. Hospital findings indicated consistent with possible heat exhaustion and diagnosed with a urinary tract infection (UTI) with antibiotic administration. The report further indicated, in view of the lack of any other findings, Resident #2 did not warrant admission to the hospital at this point in time, however, it indicated that the hospital will be unable to send Resident #2 back to the facility on 4/15/26 because there was still no air conditioning. Plan to keep Resident #2 overnight until tomorrow and once the conditions are better, Resident #2 can be safely discharged back to the facility on oral antibiotics. Nursing note dated 4/16/26 at 20:27 (8:27 PM) identified Resident #2 returned this afternoon from the hospital, on oral antibiotic for UTI. 2.Resident #3's diagnoses included chronic obstructive respiratory failure, dementia, emphysema, diabetes mellitus, and anxiety disorder. The Resident Care Plan (RCP) dated 3/17/26 identified Resident #3 has a deficit in self-care function due to dementia, COPD, and chronic respiratory failure requiring supplemental oxygen. Interventions directed to administer medications as (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered The quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS score of fifteen out of fifteen (15/15), indicative of being cognitively intact, required moderate assistance with ADL's (activities of daily living) and was independent with ambulation. Review of the EMS Run Sheet dated 4/15/26 at 11:46 AM identified EMS was called to the facility for Resident #3 who was acting lethargic for the past four (4) days per staff and baseline was reported as energetic and ambulatory. Staff reported a poor intake and recent weight loss. The Run Sheet noted that the 3rd floor of the facility where the resident resides was exceptionally hot and Resident #3 had a fan at the foot of the bed blowing air on him/her. Staff reported the facility air conditioning had been broken, but it is allegedly now fixed and operational. EMS transferred Resident #3 to the hospital. Nursing note dated 4/15/26 at 15:41 (3:41 PM) identified transfer to hospital for respiratory distress. Review of the hospital Emergency Department admission Documentation dated 4/15/26 at 4:56 PM identified Resident #2 presented to the hospital for the evaluation of generalized weakness, decreased oral intake and weight loss of 25 lbs since December. Resident #2 also states he/she is having chronic diarrhea since December. Per facility report, they noticed altered mental status from baseline, decreased oral intake, poor hygiene, weight loss around 25 lbs in the past 4 months. Resident #3 resided on the xxxxx floor of the facility where the air conditioning was not working and Resident #3 felt hot to the touch. Review of the facility daily punch log for 4/15/26 identified the following department heads and supervisory staff were present and working within the facility on 4/15/26: the Business Office Manager (BOM), Director of Social Services (DSS), Program Coordinator (PC), Administrator, MDS Director (MDS #1), Maintenance Worker (MW #1), Director of Human Resources (DHR), Assistant Director of Nursing Services (ADNS), Director of Housekeeping Services (DHK), and Director of Admissions (DOA). Review of The Weather Channel historical weather data for 4/15/26 identified weather conditions described as summer-like warmth with humid conditions. The report identified a daytime high temperature of 84 degrees Fahrenheit and an overnight low temperature of 54 degrees Fahrenheit. Review of the photo submitted by Person #1 identified an image dated 4/15/26 at 6:44 PM depicting a Honeywell thermostat located on Resident #2 and Resident #3's nursing unit with a temperature reading of 90 degrees F. The thermostat display appeared to have a maximum readable temperature of 90 degrees F, indicating the actual environmental temperature may have been 90 degrees F or above. Review of the Honeywell thermostat manual identified that the device utilizes two dials/indicators: one representing the set (desired) indoor temperature and the other reflecting the current ambient indoor temperature. Interview with RN #1 on 5/21/26 at 9:45 AM identified that on 4/15/26, Resident #2 exhibited symptoms concerning a possible stroke, prompting RN #1 to notify APRN #1, who directed to send Resident #2 to the hospital for evaluation. RN #1 stated the facility environment was noted to be hot on that date but was unable to provide an exact temperature reading. RN #1 stated the hot temperatures put residents at increased risk for dehydration and staff provided residents with water and ice-filled pitchers for hydration. Interview with Resident #4 on 5/21/26 at 10:00 AM identified that during an unknown period of time in April 2026, the temperatures on the unit felt excessively hot, which interfered with his/her ability to sleep comfortably. Resident #4 further identified he/she received a fan until approximately two weeks prior to the interview (beginning of May). Interview with LPN #4 on 5/21/26 at 10:20 AM identified that during April 2026, on an unknown date, the temperatures on Resident #2 and Resident #3's unit were excessively hot. LPN #4 stated he/she did not believe the air conditioning system was malfunctioning, however, the facility had not yet activated or set up the air conditioning units for the season. LPN #4 further stated the temperatures on the unit were approximately 90 degrees F. Interview with the Director of Maintenance (DOM) on 5/21/26 at 11:45 AM identified that during April 14 to 16, 2026, the facility experienced an abnormal heat wave and staff provided extra hydration, portable air conditioning units were installed in the dining rooms, and fans were distributed to residents considered most at risk for heat-related illness. The DOM stated a complaint was received from the local health department regarding hot room temperatures, and the facility typically changes (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the HVAC system over to air conditioning in May, however due to the hot temperatures, the air conditioning was started early on 4/17/26 (two days after Residents #2 and #3 were sent to the hospital). interview identified although facility temperatures were recorded on 4/16 and 4/17/26, no temperatures were provided for 4/15/26. Interview with Person #1 on 5/21/26 at 11:55 AM identified when he/she entered Resident #2's room, he/she noted the temperature to be excessively hot and he/she notified the staff. Person #1 viewed the thermostat and identified it read a current temperature of 90 degrees F. Person #1 stated Resident #2 was hot with dry skin and poor skin turgor, and he/she believed Resident #2 was exhibiting signs and symptoms consistent with heat exhaustion. Review of the facility undated Heat and Humidity Policy directed in part, the facility will ensure to every possible extent that the effect of heat and humidity on residents, staff, and visitors is limited. The facility is fully, centrally air-conditioned with individual room AC units and roof top HVAC units for the common areas. The effects of heat and humidity may be detrimental to an individual's well-being. Therefore, the following guidelines and procedures will be in effect whenever summer weather causes extremes in temperature (approximately 90 degrees), in order to make the internal environment of the facility as comfortable as possible and the residents free from side-effects of the heat.

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F 0689 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for elopement, the facility failed to ensure elopement risk assessments were performed timely for a resident that eloped from the facility without staff knowledge. The findings include: Resident #1's diagnoses included schizoaffective disorder, Wernicke's encephalopathy, diabetes mellitus, and epilepsy. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen (14/15), indicating of being cognitively intact, had no wandering behaviors and ambulated independently. The Resident Care Plan (RCP) dated 4/9/26 identified Resident #1 had impaired thought processes related to schizoaffective disorder, suicidal ideations, Wernicke's encephalopathy, and alcohol dependence. Interventions directed to provide cues, reorient, and supervise as needed. Facility reportable event dated 4/17/26 identified at approximately 1 PM, nursing staff were nursing alerted by staff that Resident #1 was walking up the driveway. Resident #1 went all the way to the road where another staff member was with him until other staff came to keep resident safe. Resident #1 agreed to come back to building, psychiatric APRN was notified and a new elopement assessment was completed with a wander guard placed. Clinical record review identified the most recent documented elopement risk assessment for Resident #1 was completed on 11/2/24 (one year, five months and fifteen days prior to the elopement), at which time the resident was assessed as not being at risk for elopement. Record review failed to identify any additional elopement risk assessments were conducted prior to the incident on 4/17/2026. Facility Reportable Event Summary dated 4/22/26 identified Resident #1 was not previously identified as an elopement risk. On 4/17/26 Resident #1 was sitting on a bench outside the facility with other residents and was wearing a tee shirt with a brown jacket, jeans, and sneakers. Prior to going outside, Resident #1 told a staff member that a friend was coming to pick him/her up and they were going to the diner. The staff member asked if the friend was planning on coming inside to sign him/her out and Resident #1 responded yes. The staff member had concerns about this story and watched Resident #1 outside from the receptionist's desk and when the staff member was able to leave the desk, she went down the hall to inform another staff member of her concerns. Approximately five minutes later the staff member went outside to check on Resident #1, but he/she was not there. The employee asked another resident outside if he/she saw Resident #1 and the other resident stated he/she walked up the hill. The employee returned inside the building and reported this to multiple other staff members. Four (4) staff members immediately went up the hill to locate Resident #1 and when they reached the road, an off-duty staff member was already with Resident #1 and Resident #1 stated he/she was walking to the diner to wait for a friend to pick him/her up. Resident #1 returned to the facility with no injuries identified, and a new elopement assessment was completed. Interview with the Director of Nursing (DON) on 5/20/26 at 12:15 PM identified nursing staff are responsible for completing resident elopement risk assessments within the electronic medical record system upon admission, readmission, and with a change in resident condition. Interview identified although the staff member who had the conversation with Resident #1 before he/she went outside indicated they had concerns about Resident #1's story and watched him/her from the receptionist desk before going to tell other staff, interview failed to identify why the staff member had concerns, why another staff member did not supervise Resident #1 when the employee left the reception desk, and why an elopement assessment had not been completed for Resident #1 since 11/2/24, one (1) year, five (5) months and fifteen (15) days prior to the elopement. Review of the Elopement Policy dated 12/2025 identified an elopement is an unauthorized absence of a resident from the facility who is unable to make decisions due to mental capacity or guardianship. Residents will be accounted for. The facility will evaluate and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	identify residents who are at risk for elopement from the facility by completing the Elopement Risk Evaluation in PCC. A risk evaluation will be done on new admissions and with a change of resident's condition.