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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility policy/procedures and interviews for one sampled resident (Resident #53) with a diagnoses of Alzheimer's disease, the facility failed to notify the resident's responsible party (Person #1) when a new medication (Namenda) was added to the medication regimen. The findings include: Resident #53's diagnoses included Alzheimer's disease and dysphagia The annual MDS assessment dated [DATE] identified Resident #53 had severely impaired cognition and was independent with ambulation and bed mobility. The APRN's note dated 11/6/24 identified Person #1 was against the use of Namenda and did not want any new medications to be added to Resident #53's medication regimen. The APRN's note dated 11/22/24 identified that education was provided to Person #1, who continued to refuse the use of Namenda. The APRN's note dated 12/5/24 identified Person #1 continued to refuse the use of Namenda, despite education. The APRN's note dated 12/27/24 identified Person #1 declined use of Namenda. The physician's order dated 2/21/25 directed Namenda 5mg to be administered twice daily by mouth. Review of the medication administration record (MAR) for the period of 2/22/25 through 2/28/25 identified Namenda 5mg was administered to Resident #53 twice daily. Review of nurses 'notes dated from 2/21/25 through 2/28/25 failed to identify Person #1 was notified of the new order for Namenda. Review of the MAR for the month of March 2025 identified Resident #53 was administered Namenda 5mg twice daily. Review of the MAR for the month of April 2025 identified Resident #53 was administered Namenda 5mg twice daily. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the MAR for the month of May 2025 identified Resident #53 was administered Namenda 5mg twice daily. Observation on 5/29/25 at 10:44 AM identified Resident #53 seated in the dining area at a table appearing to be asleep while there was a recreation activity in progress. Review of the MAR for June 2025 identified Namenda 5mg twice a day was administered on 6/1/25 and on 6/2/25 (AM does only). Interview on 6/2/25 at 12:47 PM with Person#1 identified that he/she was unaware that Resident #53 had an order and was being administered Namenda, because he/she had verbalized to many people that after reviewing the medication uses and side effects, he/she was of the opinion that it would not benefit Resident #53. Person#1 identified she had not spoken to the doctor, but when she spoke with APRN#1 she made it clear she did not want the medication added to the medication regimen. Person#1 indicated she expected that the facility would notify her of any changes in order to have input regarding the medication management and identified that no one from the facility had notified her about the addition of the Namenda and that during Resident #53's care conference held in May, she was not notified about any changes or additions. Interview on 6/2/25 at 12:37 PM with LPN #4 identified that when the physician/APRN adds an order to the computer it needs to be approved. The person who approves the order should notify the responsible party. She further noted that the Namenda order was approved by the RN supervisor, but there was no documentation that she notified Person #1. Interview on 6/2/25 at 12:46 PM with the DNS indicated the doctor entered the order into the electronic medical record and an RN supervisor approved the order. The expectation is that the RN Supervisor who approves the order also notify the family (responsible party). The DNS further identified there should be a progress note written to identify the family was notified. Interview on 6/2/25 at 1:01 PM with the ADNS identified she is sometimes asked to represent nursing during a care conference meeting. The ADNS indicated If there were no changes, then I don't list out the medications, but can be reviewed if the family has questions. The ADNS identified she looks in the chart to see any dates of anything discontinued or completed. Looking through Resident#53's chart, the ADNS did not identify the Namenda as a new medication and indicated she does a quick review of the chart and does not go back to the previous care conference. Although requested, the facility failed to provide a facility policy regarding notification of changes.

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and interviews for one sampled resident (Resident #125) reviewed for discharge, the facility failed to ensure the Ombudsman's office was provided with the required notification of the transfer. The findings include: Resident #125's diagnoses included acute osteomyelitis of left foot and ankle and type 2 diabetes mellitus with diabetic neuropathy. The admission MDS assessment dated [DATE] identified Resident #125 had intact cognition, required moderate assistance with toileting hygiene, upper and lower body dressing, personal hygiene, bed mobility and transfers and utilized a walker with ambulation. The Social Worker (SW #1) progress note dated 3/20/25 at 3:04 PM identified she met with Resident #125 to review his/her discharge for 3/21/25 and indicated that transportation was booked. The note further identified Resident #125 was reluctant to use homecare services and was informed that a referral was made. RN #4's progress note dated 3/21/25 at 12:58 PM identified Resident #125 was discharged home with health services set up, and medications and discharge instructions were reviewed with the resident with no questions. A request was made on 6/2/25 for the Ombudsman's report of transfers and discharges for the last four months. The Social Worker (SW #1) conveyed that she was behind in reporting to the Ombudsman's office. A review of the documentation provided by the facility identified that the last report sent to the State Ombudsman's office regarding resident admissions, discharges, and transfers was last completed in February 2025. Review of the facility's admission, discharge, and transfer report for the past three months identified the following: for the month of February, there were forty-one residents discharged and/or transferred from the facility; for the month of March, there were forty-one residents discharged and/or transferred from the facility; for the month of April, thirty-four residents were discharged and/or transferred from the facility. Interview with SW #1 on 6/2/25 at 11:34 AM identified she is responsible for sending reports of each month's transfers and discharges to the Ombudsman's office. SW #1 indicated that she was unaware that the reports should be sent on a monthly basis. She identified that she would send in a couple of months at a time via the ombudsman's reporting portal but had fallen behind recently. Interview with the Administrator on 6/2/25 at 12:08 PM identified it was the responsibility of SW #1 to submit the report via the ombudsman's portal on a monthly basis. The report should contain the residents that were discharged for any reason and/or transferred for any reason. She further identified she was not aware of SW #1 being behind in sending the monthly report. (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	On 6/2/25 (after surveyor inquiry) the facility updated the Ombudsman's office of all discharges and transfers that occurred during the period of February/2025 through May/2025. An interview with the Administrator on 6/2/25 at 12:08 PM identified that the facility does not have a written policy regarding notification of discharges and transfers to the Ombudsman office, but it was the facility's practice and the social worker's responsibility to submit the report monthly.

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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 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.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility policy, review of facility documentation, and interviews for two of five sampled residents (Resident #17 and Resident #95) reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was assessed/and administered to the resident when requested. The findings include: 1. Resident #17 was admitted to the facility in December of 2024 and had diagnoses that included Alzheimer's disease, atrial fibrillation, and chronic systolic congestive heart failure. The quarterly MDS assessment dated [DATE] identified Resident #17 had severely impaired cognition. The assessment further identified that Resident #17 had not received the pneumococcal vaccine as it was not offered. Review of the Consent Form for Pneumococcal Vaccination Series (PCV/PPSV23) identified Resident #17 gave the facility permission to administer/complete the pneumococcal series as directed by the Center for Disease Control and Prevention (CDC) guidelines and physician on 12/10/24. Review of Resident #17's clinical records with the Infection Preventionist (LPN #1) on 5/29/25 at 12:03 PM failed to identify that he/she had received any of the pneumococcal vaccines while at the facility. The records also did not contain any documentation that the resident had refused the vaccine. Interview with LPN #1 on 5/29/25 at 12:03 PM identified Resident #17 should have received the vaccine if he/she had given consent to the vaccine administration. She identified it was the Infection Preventionist's (IP) responsibility to review the consent form, obtain a physician's order, order the vaccine and ensure that it was administered to the resident. She further identified that she was not working at the facility during the time the resident had requested the vaccine, and it was the responsibility of the previous IP nurse to ensure the resident had received the vaccine. Review if the Pneumococcal Vaccination policy identified all residents admitted to this facility will be evaluated to determine if they have received Pneumococcal Vaccination. The facility will offer pneumococcal immunization, unless immunization is medical contraindicated, or the resident has already been immunized upon resident and or responsible party consent, the PCV15, PCV 20 vaccine and the PPSV23 will be offered per the CDC guidelines as indicated. 2. Resident #95's diagnoses included type 2 diabetes mellitus, Alzheimer's disease, chronic kidney disease stage 3 and hyperlipidemia. The quarterly MDS assessment dated [DATE] identified Resident #95 had severely impaired cognition. The assessment further identified that Resident #95 had not received the pneumococcal vaccine as it was not offered. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #95's clinical records with the Infection Preventionist (LPN #1) on 5/29/25 at 12:03 PM failed to identify that he/she had any prior vaccination history of the pneumococcal vaccines or was offered the vaccine while at the facility. The records also did not contain any documentation that the resident had refused the vaccine. Interview with LPN #1 on 5/29/25 at 12:03 PM identified that all resident is offered the pneumococcal vaccine on admission by the admitting nurse, which is then reviewed by the Infection Preventionist (IP). The IP nurse is responsible for reviewing the consent, obtaining the physician's order, order the vaccine and then it would be administered to the resident. She identified that she was not working at the facility during the time the Resident #95 was admitted , and it was the responsibility of the previous IP nurse to ensure the resident was offered and assessed for the pneumococcal vaccine. Review if the Pneumococcal Vaccination policy identified all residents admitted to this facility will be evaluated to determine if they have received Pneumococcal Vaccination. The facility will offer pneumococcal immunization, unless immunization is medical contraindicated, or the resident has already been immunized upon resident and or responsible party consent, the PCV15, PCV 20 vaccine and the PPSV23 will be offered per the CDC guidelines as indicated.