STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075354	A. Building B. Wing	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint John Paul II Center	33 Lincoln Avenue Danbury, CT 06810

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** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for medication administration, the facility failed to ensure the physician was notified when the resident refused medication. The findings include: 1. Resident #1 had diagnoses that included seizures, anxiety, depression, attention-deficit hyperactivity disorder, and gender identity disorder. The care plan dated 10/8/24 identified Resident #1 exhibits or has the potential to demonstrate verbal behaviors related to anxiety, depression, ADHD, gender identity crisis, and Resident #1 is at risk for seizure activity with interventions that directed to medicate as ordered and monitor for effectiveness as well as side effects report to physician as needed and monitor medications especially new/changed/discontinued for side effects and resident's response contributing to verbal behaviors. a) A physician's order dated 10/9/24 directed to administer Primidone 50 milligram (MG) (anticonvulsant used to control seizures) oral tablet give 25 MG by mouth every morning for anticonvulsant. The quarterly MDS dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and was independent with ADLs. A review of Resident #1's Medication Administration Record (MAR) from 11/1/24 to 11/30/24 identified Resident #1 refused h/her morning doses of Primidone 25 MG a total of 18 days out of 30 days during the month of November 2024. b) A physician's order dated 10/9/24 directed to administer Hydroxyzine 25 MG in the morning by mouth for anxiety. A review of Resident #1's MAR from 11/1/24 to 11/30/24 identified Resident #1 refused h/her Hydroxyzine 25 MG morning doses for a total of 10 days out of 30 days during the month of November 2024. (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	Interview with LPN #1 (7:00 AM- 3:00 PM charge nurse) on 12/26/24 at 12:13 P.M. identified Resident #1 would often refuse his/her morning Primidone dose at times Resident #1 would refuse h/her Hydroxyzine medication. LPN #1 indicated it got to the point where Resident #1 would tell her what medications h/she was willing to take. LPN #1 indicated she could not recall if she notified the MD or APRN when Resident #1 refused medications or if she wrote a nurse's note. LPN #1 identified she is responsible for writing a nurse's note and notifying the MD or APRN when a resident refuses medications. An interview with RN #1 (unit manager) on 12/26/24 at 10:00 A.M. identified she was not aware, and she could recall if it had been reported to her that Resident #1 had been refusing h/her medications. RN #1 indicated when a resident refuses medication the expectation is the charge nurse notifies the APRN, writes a nurse's note, and a care plan is implemented for medication refusals. RN #1 identified her expectation is that the charge nurse notifies her when a resident refuses h/her medication. Interview with APRN #1 on 12/26/24 at 10:45 A.M. identified she was not aware Resident #1 had been refusing medications. APRN #1 indicated if she had been notified, she would have educated Resident #1 on the benefits of taking medications as ordered and the potential consequences of non-compliance with h/her medication regimen. APRN #1 identified her expectation is that she is notified when a resident refuses medication. Interview and clinical record review with the DNS on 12/26/24 at 11:15 A.M. she was unable to provide documentation to reflect when Resident #1 refused h/her medications MD #1 or APRN #1 were notified. The DNS indicated her expectation is when a resident refuses h/her medications the charge nurse notifies the physician or APRN. The DNS identified when Resident #1 refused h/her medications the charge nurse should have notified the physician or APRN. Review of facility medication administration undated policy, in part, identified resident's refusal of medication the MD must be notified notified.

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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 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** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to develop and implement a comprehensive care plan to address the resident's history of often refusing medications. The findings include: Resident #1 had diagnoses that included seizures, anxiety, depression, attention-deficit hyperactivity disorder, and gender identity disorder. The care plan dated 10/8/24 identified Resident #1 exhibits or has the potential to demonstrate verbal behaviors related to anxiety, depression, ADHD, gender identity crisis, and Resident #1 is at risk for seizure activity with interventions that directed to medicate as ordered and monitor for effectiveness as well as side effects report to physician as needed and monitor medications especially new/changed/discontinued for side effects and resident's response contributing to verbal behaviors. A physician's order dated 10/9/24 directed to administer Primidone 50 milligram (MG) (anticonvulsant used to control seizures) oral tablet give 25 MG by mouth every morning for anticonvulsant and administer Hydroxyzine 25 MG by mouth every morning for anxiety. The quarterly MDS dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) of fourteen (14) indicative of intact cognition and was independent with ADLs. A review of Resident #1's Medication Administration Record (MAR) from 11/1/24 through 11/30/24 identified Resident #1 refused h/her daily Primidone 25 MG morning dose 18 days out of 30 days and Resident #1 refused h/her daily Hydroxyzine 25 MG morning dose 10 day out of 30 days. A review of the nurse's notes from 11/1/24 to 11/30/24 identified only one nurse's note written on 11/26/24 at 9:10 A.M. by LPN #1 who identified Resident #1 refused Primidone oral tablet 50 MG give 25 MG by mouth every morning and Resident #1 refused Hydroxyzine 25 MG give 25 MG by mouth every morning for anxiety. Interview with RN #1 (unit manager) on 12/26/24 at 10:00 A.M. identified when a resident refuses to take medication the resident should have a care plan implemented with appropriate interventions. RN #1 identified Resident #1 should have had a care plan implemented for medication refusals with appropriate interventions in place. Interview and clinical record review with the DNS on 12/26/24 at 11:15 A.M. identified her expectation when a resident is refusing medications is that a comprehensive care plan is implemented with interventions. The DNS was unable to provide documentation to reflect that Resident #1 had a comprehensive care plan implemented for medication refusals. The DNS identified Resident #1 should have had a comprehensive care plan in place to identify and address Resident #1's refusals of medications. The DNS was unable to explain why Resident #1 did not have a comprehensive care plan implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility person-centered care plan policy dated 10/24/22; in part, identified the care plan must be customized to each individual patient's preferences and needs and the comprehensive person-centered care plan must be developed for each patient and must describe any services that would otherwise be required, but are not provided due to the patient's exercise of rights, including the right to refuse treatment.