

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2025
NAME OF PROVIDER OR SUPPLIER  Saint John Paul II Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for discharge, the facility failed to provide discharge education for a diabetic resident newly prescribed insulin and failed to ensure medication reconciliation prior to discharge resulting in a resident being discharged home without prescribed medications and supplies. The findings include:</p> <p>a. Resident #1 had diagnoses that included type 2 diabetes mellitus, zoster, lack of coordination, and pneumonia.</p> <p>Review of a hospital note dated 2/16/2025 at 5:23 P.M. by MD #2 identified Resident #1 would start taking a steroid, h/her blood sugars may increase, and to continue with insulin sliding scale.</p> <p>The nursing admission assessment dated [DATE] at 1:49 P.M. by the Assistant Director of Nurses (ADNS) identified care management teaching and training education was not provided.</p> <p>APRN #1's note dated 2/24/2205 at 9:18 P.M. identified Resident #1's blood sugar levels were elevated in the setting of steroid use and were managed with insulin sliding scale.</p> <p>The Resident Care Plan dated 2/24/2025 identified Resident #1 had diabetes mellitus with nephropathy and interventions including diabetes medication as ordered by the provider, monitor and document for side effects and effectiveness, educate regarding medications and importance of compliance, have the resident verbally state an understanding, educate resident on diabetes as a chronic disease and that compliance is essential to prevent complications, review complications and prevention with the resident, elicit a verbal understanding from the resident, monitor/document/report any signs or symptoms of hyperglycemia or hypoglycemia.</p> <p>A physician's order dated 2/24/2025 directed to administer Insulin Lispro (a medication for diabetes mellitus) per sliding scale: if blood sugar is 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 399 = 10 units above 400 call MD, intramuscularly three times daily for diabetes mellitus.</p> <p>A social service note dated 3/12/2025 at 3:56 P.M. by Social Worker (SW) #1 identified she met with Resident #1 for discharge planning and Resident #1 stated h/she was not ready for discharge and had stairs at home. The note indicated Resident #1's plan was to discharge home when h/she was able to and started working on stairs with therapy.</p> <p>(continued on next page)</p>

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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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Notice of Medicare Non-Coverage (NOMNC) dated 3/12/2025 identified Resident #1's Medicare coverage would end on 3/14/2025.</p> <p>The Quality Improvement Organization (QIO) dated 3/13/2025 identified Resident #1 requested an appeal and based on review of the medical record it was determined that termination of skilled services was appropriate.</p> <p>A social service note dated 3/14/2025 at 10:23 A.M. by SW #1 identified Resident #1's discharge plan documentation, discharge summary, and transition plan were completed.</p> <p>The discharge plan documentation dated 3/14/2025 at 10:23 A.M. by SW #1 and RN #1 (unit manager) identified Resident #1's estimated/scheduled discharge date was 3/15/2025 at 11:00 A.M. to h/her home alone with home health services and that Resident #1 had no changes or discontinuation of h/her medications. RN #1 indicated that Resident #1's current reconciled medication list was provided to the subsequent provider.</p> <p>APRN #1's note dated 3/14/2025 at 12:57 P.M. identified Resident #1 was seen for a physical assessment for a possible discharge to home/community on 3/15/2025. APRN #1 identified SW #1 notified her Resident #1 was no longer covered by insurance and Resident #1 agreed to discharge home. The note identified Resident #1 had h/her own medications that were brought to the facility on admission to the facility. The note identified Resident #1 was to continue current medication orders and that Resident #1 was educated to continue taking medications as ordered.</p> <p>The discharge summary medication list dated 3/14/2025 directed to inject Insulin Lispro as per sliding scale: if blood sugar is 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 399 = 10 units above 400 call MD, intramuscularly three times a daily.</p> <p>A physician's order dated 3/15/2025 directed to discharge Resident #1 to home/community on 3/15/2025.</p> <p>Nurse's progress notes from 2/24/2025 to 3/15/2025 failed to identify documentation to reflect education on management of diabetes mellitus, how to obtain a blood sugar with the use of a glucometer, use and action of Insulin Lispro, insulin sliding scale, or how to self-inject insulin.</p> <p>A nurse's note dated 3/15/2025 at 10:47 A.M. by RN #1 indicated she reviewed all medications with Resident #1, h/she stated understanding of use and classification, and h/she was discharged home with services.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #1 on 4/4/2025 at 9:45 A.M. indicated that identified educational needs for residents should be addressed before residents discharge and any medical equipment should be ordered. RN #1 identified that Lispro Insulin was a new medication for Resident #1 since the most recent hospitalization. RN #1 identified that Resident #1 required education on diabetes management which included the use of Lispro Insulin, sliding scale, how to inject insulin, and how to obtain blood sugars using a glucometer. RN #1 identified Resident #1 was not provided with education during h/her admission to the facility and could not explain why. RN #1 identified on 3/18/2025 (3 days after discharge) she went to Resident #1's home with a glucometer, the required supplies to obtain blood sugars, and provided verbal education to Resident #1. RN #1 identified that she did not communicate to APRN #1 that Resident #1 needed a glucometer, and supplies ordered. RN #1 identified that Resident #1 should have been provided with education prior to h/her discharge on [DATE].</p> <p>Interview with RN #2 on 4/4/2025 at 11:52 A.M. identified on 3/15/2025 when Resident #1 was discharged she was not aware that Resident #1 required education on how use a glucometer to check blood sugars, how to administer Lispro Insulin, how to self- inject insulin, or when to notify a provider. RN #2 indicated residents are supposed to be provided with education throughout their stay at the facility not just on the day of discharge.</p> <p>Interview with APRN #1 on 4/4/2025 at 11:25 A.M. identified upon admission resident's educational needs were identified and addressed. APRN #1 identified the nurses should provide residents with education and ensure residents verbalize understanding prior to discharge. APRN #1 identified that Resident #1's educational needs should have been addressed prior to h/her discharge home on 3/15/2025. APRN #1 identified that RN #1 did not notify her that Resident #1 needed a prescription for a glucometer and glucometer supplies.</p> <p>Interview with the DNS on 4/4/2025 at 1:00 P.M. identified that education on disease management, medication, and post-discharge is initiated based on residents identified needs upon admission to the facility. The DNS indicated nurses initially provide verbal education and when required, nurses demonstrate how to use different medical equipment. The DNS indicated nurses should have residents verbalize understanding and redemonstrate skills to assess understanding of the education. The DNS identified that Resident #1 was not provided with diabetes education or demonstrations on how to use a glucometer to obtain a blood sugar level or Lispro Insulin administration during admission to the facility. The DNS identified that RN #1 should have ensured that Resident #1 was educated and verbalized understanding of the education prior to discharge, and a glucometer should have been provided at the time of discharge.</p> <p>b. Resident #1 had diagnoses that included type 2 diabetes mellitus, zoster, lack of coordination, and pneumonia.</p> <p>A physician's order dated 2/24/2025 directed to administer Insulin Lispro (a medication for diabetes mellitus) per sliding scale: if blood sugar is 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 399 = 10 units above 400 call MD, intramuscularly three times a daily for diabetes mellitus.</p> <p>A physician's order dated 2/28/2025 directed to administer gabapentin (a medication used to treat nerve pain) 100 milligrams three times a day for pain.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of thirteen indicative of intact cognition, was occasionally incontinent of bowel and bladder, required partial assistance with ADLs, bed mobility, and transfers.</p> <p>The Resident Care Plan dated 3/3/2025 identified Resident #1 had the potential for discharge or was expected to be discharged related to the resident's desire to discharge to the community and admission for skilled short-term stay. Interventions directed to identify, discuss, and document resident desires and concerns/barriers regarding discharge, evaluate discharge planning needs taking into consideration care plans, resident/patient goals, cognitive skills, functional mobility and need for assistive devices, identify educational needs with the resident and initiate an education care plan, provide ongoing communication to the interdisciplinary team (IDT) members, physician/mid-level provider, and resident about the discharge planning process, and make referrals to community-based agencies, providers, and services communicating the residents needs and barriers to care.</p> <p>A social service note dated 3/12/2025 at 3:56 P.M. by Social Worker (SW) #1 identified she met with Resident #1 for discharge planning and Resident #1 stated h/she was not ready for discharge and had stairs at home. The note indicated Resident #1's plan was to discharge home when h/she was able to and started working on stairs with therapy.</p> <p>The Notice of Medicare Non-Coverage (NOMNC) dated 3/12/2025 identified Resident #1's Medicare coverage would end on 3/14/2025.</p> <p>The Quality Improvement Organization (QIO) dated 3/13/2025 identified Resident #1 requested an appeal and based on review of the medical record it was determined that termination of skilled services was appropriate.</p> <p>A social service note dated 3/14/2025 at 10:23 A.M. by SW #1 identified Resident #1's discharge plan documentation, discharge summary, and transition plan were completed.</p> <p>Review of the discharge plan documentation dated 3/14/2025 at 10:23 A.M. by SW #1 and RN #1 (unit manager) identified Resident #1's estimated/scheduled discharge date was 3/15/2025 at 11:00 A.M. to h/her home alone with home health services and that Resident #1 had no changes or discontinuation of h/her medications. RN #1 indicated that Resident #1's current reconciled medication list was provided to the subsequent provider.</p> <p>APRN #1's note dated 3/14/2025 at 12:57 P.M. identified Resident #1 was seen for a physical assessment for a possible discharge to home/community on 3/15/2025. APRN #1 identified SW #1 notified her Resident #1 was no longer covered by insurance and Resident #1 agreed to discharge home. The note identified Resident #1 had h/her own medications that were brought to the facility on admission. The note identified Resident #1 was to continue current medication orders and Resident #1 was educated to continue taking medications as ordered.</p> <p>Review of Resident #1's discharge summary medication list dated 3/14/2025 directed to take gabapentin 100 milligram (a medication used to treat nerve pain) capsule three times per day and inject Insulin Lispro per sliding scale: if blood sugar is 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 399 = 10 units above 400 call MD, intramuscularly three times a daily.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nurse's note dated 3/15/2025 at 10:47 A.M. by Registered Nurse (RN) #1 indicated she reviewed medications with Resident #1 and h/she stated understanding of use and classification. The note identified that Resident #1 was discharged home with services.</p> <p>Review of the Facility's Accident and Incident Form dated 3/18/2025 at 3:00 P.M. identified the home care nurse assigned to Resident #1 called the facility with a concern that Resident #1's medications, discharge teaching, and instructions were not provided upon discharge.</p> <p>Review of APRN #1's note dated 3/18/2025 at 5:04 P.M. identified she was notified by SW #1 that Resident #1 was discharged on 3/15/2025 without h/her Insulin Lispro and gabapentin and further indicated she was told not to call prescriptions in to the pharmacy on the day of discharge. The note indicated she was informed Resident #1 brought all home medications into the facility and h/she would be discharging with all home medications. The note identified Resident #1 was currently prescribed Insulin Lispro but based on review of blood sugar levels, she would be discontinuing Insulin Lispro and would order Insulin Glargine 3 units at bedtime instead. The note identified she ordered gabapentin 100 milligram capsule three times per day for pain, Glargine insulin 3 units at bedtime, Insta-Glucose Gel, a glucometer, test strips, lancets, a lancing device, alcohol pads, cotton balls/gauze, and a blood sugar logbook, from the pharmacy.</p> <p>Review of a statement dated 3/20/2025 at 7:33 P.M. by RN #1 identified she discussed Resident #1's discharge medications with APRN #1 and informed APRN #1 that Resident #1 already had h/her medications. RN #1 identified she overlooked two medications that were part of Resident #1's active discharge orders, and she did not complete discharge teaching with Resident #1 for insulin administration and blood sugar monitoring.</p> <p>Review of the Facility Accident and Incident and Summary dated 3/21/2025 identified that on 3/18/2025 the home care nurse assigned to Resident #1 called the facility with a concern that medications and teaching/instructions were not provided upon discharge. An investigation was initiated that identified RN #1 did not clearly communicate to APRN #1 what medications needed to be ordered and RN #1 told APRN #1 that Resident #1 did not need any medications ordered since Resident #1 was taking h/her home medications back home upon discharge. The summary identified discharge medications should have included gabapentin and Lispro Insulin per sliding scale and, on 3/18/2024, RN #1 went to Resident #1's home to provide Resident #1 with discharge teaching and instructions and to reconcile medications.</p> <p>Interview with RN #1 on 4/4/2025 at 9:45 A.M. identified she was responsible for Resident #1's discharge on [DATE]. RN #1 identified on 3/14/2025 while preparing Resident #1's discharge packet she did not conduct a pre and post medication reconciliation. RN #1 identified she should have reconciled the medications to ensure Resident #1 had all medications upon discharge.</p> <p>Interview with APRN #1 on 4/4/2025 at 11:25 A.M. identified that on 3/14/2025 RN #1 informed her that Resident #1 had all medications for discharge home on 3/15/2025. APRN #1 identified on 3/18/2025 SW #1 notified her that Resident #1's home care nurse notified the facility Resident #1 did not have gabapentin or Lispro Insulin at home. APRN #1 identified she then called prescriptions and all necessary supplies into the pharmacy. APRN #1 identified a reconciliation of all pre-discharge and post-discharge medications should be conducted for discharge and RN #1 should have reconciled Resident #1's medications.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 4/4/2025 at 1:00 P.M. identified on 3/18/2025 when she was notified by a home care nurse that Resident #1 was missing medications, she initiated an investigation. The DNS identified, based on her investigation, that RN #1 did not reconcile Resident #1's medications resulting in Resident #1 not having a supply of gabapentin and Lispro Insulin. The DNS identified that when a resident is being discharged, medications should be reconciled and RN #1 should have reconciled Resident #1's pre-discharge medications with post-discharge medications.</p> <p>Review of facility discharge planning process policy dated May 2024; in part, identified the discharge transition plan must include but is not limited to: a reconciliation of all pre-discharge medications with the patient's post-discharge medications (both prescription and over-the counter), identify discharge needs and develop a plan to meet those needs, and provide ongoing support, encouragement, and education to patients and patient representatives.</p>		