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	08/21/2025

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 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. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one sampled resident (Resident #1) who was reviewed for an allegation of abuse, the facility failed to ensure Resident #1 was free from physical contact with a staff member. The findings include:Resident #1's diagnoses included surgical aftercare of the circulatory system, dysthymic disorder, pleurodynia, dissection of aorta, thrombocytopenia, hypertensive heart disease without heart failure, depression and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was alert and oriented to person, place, and time. The Resident Care Plan dated 5/14/25 identified Resident #1 at risk for injury or complications related to the use of antiplatelet therapy medication. Interventions directed to give medication as ordered, monitor for cyanosis and pallor, observe for complaints of pain of bone, abdomen, or joint, and observe for active bleeding. The nurse's note dated 7/26/25 at 5:24 AM identified at 5:00 AM Resident #1 informed the charge nurse, Licensed Practical Nurse (LPN) #1, he/she wanted to make a complaint that a nurse aide, Nurse Aide (NA) #1, grabbed his/her wrist too hard. The note indicated there was no injury, Resident #1 was upset and wanted to make a report to the police. The note identified NA #1 was sent home, the police were notified as well as the provider. The Facility Reported Incident form identified on 7/26/25 Resident #1 reported to the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1, that the agency nurse aide, NA #1, grabbed his/her right wrist too hard, he/she was not hurt, but wanted to report the incident to the police., who were called and came to the facility to get the report. Review of the written statement signed by Resident #1 identified on 7/26/25 during the early morning hours, NA #1 was arguing and yelling with LPN #1 in the hallway when Resident #1 went out to the hallway and asked NA #1 why are you so loud at which time NA #1 walked towards Resident #1 and put his hand over Resident #1's right wrist. Resident #1 identified he/she pulled away from NA #1 and stated, don't touch me to which NA #1 allegedly stated you are not black. Review of LPN #1's written statement dated 7/26/25 identified during the shift, NA #1 reported to her that a resident had refused incontinent care. LPN #1 identified she informed NA #1 that Resident #1 had a history of initially refusing and she would go in and speak with Resident #1. LPN #1 indicated she spoke with Resident #1 and reported to NA #1 Resident #1 was willing to accept incontinent care, but at that point, NA #1 refused to provide the care without LPN #1 going into the room with him. LPN #1 identified she informed NA #1 Resident #1 did not require two (2) staff members for care, she was in the process of doing her medication pass and could not assist in the room at that time. LPN #1 identified NA #1 began to yell you're racist repetitively walking out of the room into the hallway and then touching his skin stating, my skin is black, not yours, you're racist. LPN #1 identified NA #1 continued yelling in the hallway while residents were in the hallway asking what was going on. LPN #1 identified Resident #1 stood outside of his/her room and stated to NA #1, why are you yelling, calm down, NA #1 proceeded to reach over and grab Resident #1's right arm/wrist at which time Resident #1 stated why are you grabbing me, don't touch me and NA #1 dropped Resident #1's arm/wrist. LPN #1 indicated she went to report this to the nursing supervisor, RN #1, and Resident #1 accompanied her to report the incident. Interview with NA #1 on 8/20/25 at 10:47 AM identified he did get into a verbal altercation with LPN #1, but NA #1 identified he did not abuse anyone. Interview with the nursing supervisor, RN #1, on 8/20/25 at 11:52 AM identified on 7/26/25, LPN #1 and Resident #1 reported that NA #1 had grabbed Resident #1's right arm/wrist. RN #1 identified it was reported after NA #1 got into a verbal argument with LPN #1, Resident #1 came out of his/her room and that was when NA #1 grabbed Resident #1. RN #1 identified NA #1 was immediately sent home, the police were notified, and the provider was notified. RN #1 identified Resident #1 had no injury. Interview and clinical record review with the Director of Nursing (DON) on 8/20/25 at 12:56 PM identified it was reported that on 7/26/25, NA #1 grabbed Resident #1's right arm/wrist after he/she came out to find out why NA #1 had been arguing and yelling at LPN #1 in the hallway. The DON identified the administrator initiated an investigation and NA #1 was placed on the do not return list. The DON identified interviews were done with staff members as well as other residents on the unit. The DON identified the facility policy was zero-tolerance for abuse, and it was the responsibility of all staff to ensure the policy is followed. The DON identified NA #1 did not follow the facility policy as he had been upset. Although attempted, an interview with LPN #1 was unable to be obtained. Review of the facility policy titled Abuse and Neglect, undated, directed, in part, it is the policy of the facility to prevent any form of abuse or neglect towards a resident or residents whenever possible and to promptly and

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility policy, facility documentation and interviews for one (1) of three (3) sampled residents (Resident #2) who had a change in condition, the facility failed to ensure care and services provided were in accordance with professional standards. The findings include:Resident #2's diagnoses included hypertension, hypothyroidism, hyperlipidemia, morbid obesity, malignant neoplasm of thyroid gland and endometrium, and weakness. The physician's order dated [DATE] directed a full code and administer Cardiopulmonary Resuscitation (CPR). The resident care plan dated [DATE] identified Resident #2 had an established advanced directive, full code. Interventions directed to activate resident's advanced directives as indicated, allow opportunities for expression of feelings and ask questions, and inform the resident and/or the healthcare decision maker of any changes in status or care needs. The 5-day [NAME] data set dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #2 was alert and oriented to person, place, and time. The nurse's note dated [DATE] at 7:05 A.M. written by the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #2, identified upon assessment Resident #2 had no pulse or cardiac activity, pupils were fixed and dilated, Resident #2 had significant mottling of the feet and hands. The note indicated CPR was initiated and continued for twenty (20) minutes with no return of circulation and RN #2 pronounced Resident #2's death at 4:00 A.M. A physician's order dated [DATE] directed to release Resident #2's body to the funeral home. A review of the clinical record from [DATE] through [DATE] failed to reflect a physician's order for RN Pronouncement. Interview with NA #2 on [DATE] at 11:59 A.M. identified on [DATE] at approximately 3:30 A.M. she went to Resident #2's room to check on Resident #2 at which time she noted Resident #2 was unresponsive and appeared not to be breathing. NA #2 indicated she tried to wake up Resident #2, by calling out his/her name, tapping him/her on the shoulders, but Resident #2 did not respond. NA #2 identified she immediately notified RN #2 that Resident #2 was unresponsive and would not wake up. NA #2 indicated RN #2 grabbed the crash cart, went to check on Resident #2, and alerted LPN #1 who was on the unit down the hall. NA #2 identified RN #2 and LPN #1 were in Resident #2's room initiating CPR and she went to provide care to another resident. NA #2 indicated on [DATE] at approximately 2:00 A.M. she had observed Resident #2 lying in bed, alive, and breathing. Interview with RN #2 on [DATE] at 12:25 P.M. identified on [DATE] at approximately 3:30 A.M. NA #2 told her Resident #2 was unresponsive, not breathing, and that she thinks Resident #2 expired. RN #2 indicated she immediately grabbed the crash cart, went down to assess Resident #2. RN #2 explained Resident #2 appeared deceased , he/she was not breathing, had no cardiac activity, no pulse, the hands and feet were mottled, blue and cold, and the pupils were fixed and dilated. RN #2 indicated she alerted LPN #1, who came down to the room, and they started CPR on Resident #2. RN #2 identified she and LPN #1 continued to administer CPR for approximately 20-30 minutes, but it was not effective, and Resident #2 was still deceased . RN #2 identified she left the room to make phone calls to the on-call provider and Resident #2's family while LPN #1 continued to administer CPR. RN #2 indicated Resident #2's responsible party declined transferring Resident #2 to the hospital and stated the family would come right down to the facility to see Resident #2. RN #2 identified she did not call Emergency Medical Services (EMS) because it appeared Resident #2 had some type of cardiac arrest, CPR was not successful in resuscitating Resident #2, and Resident #2's responsible party declined transfer to the hospital. RN #2 identified she pronounced Resident #2's death on [DATE] at 4:00 A.M. without a physician's order directing an RN pronouncement. RN #2 identified that she should have called EMS so the emergency room doctor could have pronounced Resident #2's death. Interview with the Medical Director, MD #1, on [DATE] at 12:55 P.M. identified his expectations when a resident who is a full code was found unresponsive, not breathing, without a pulse, that 911 was called, and CPR is initiated. MD #1 identified that on [DATE] when Resident #2 was found unresponsive, not breathing, without a pulse, and CPR was initiated, 911 should have been called so EMS personnel could have pronounced Resident #2's death. MD #1 identified on [DATE] that Resident #2 did not have a physician's order that directed an RN pronouncement of death and RN #2 should not have pronounced Resident #2's death. Interview with the Director of Nursing (DON) on [DATE] at 1:25 P.M. identified on [DATE] when Resident #2 was found unresponsive and CPR was initiated, RN #2 should have called 911, so EMS could have pronounced Resident #2's death. The DON identified RN #2 should not have pronounced Resident #2's death and RN #2 should have known that an RN pronouncement requires a physician's order

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #2) reviewed for accidents, the facility failed to ensure a resident's neurological assessments were conducted following an unwitnessed fall. The findings include:Resident #2's diagnoses included hypertension, hypothyroidism, hyperlipidemia, morbid obesity, malignant neoplasm of thyroid gland and endometrium, and weakness. The fall risk assessment dated [DATE] at 7:35 PM completed by Registered Nurse (RN) #3 identified Resident #2 at a high risk for falls. The care plan dated 7/9/25 identified Resident #2 at high risk for falls related to confusion, deconditioning, gait and balance problems, poor communication/comprehension, psychoactive drug use, and unaware of safety needs. Interventions directed to anticipate and meet the resident's needs, be sure the call light is within reach and encourage the resident to use it for assistance as needed, the resident needs prompt response to all requests for assistance, encourage resident to ask for help prior to getting out of bed, ensure the resident is wearing appropriate footwear when ambulating, or mobilizing in wheelchair, and physical therapy to evaluate and treat as ordered and as needed. The 5-day [NAME] data set dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15) indicating Resident #2 was alert and oriented to person, place, and time, was occasional incontinent of bowel, always incontinent of bladder, dependent on staff dependent on staff for all activities of daily living, including bed mobility, and transfers, was non ambulatory and dependent on staff for mobility in the wheelchair. The Facility Reported Incident report dated 7/20/25 identified at 2:50 AM the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #2, heard Resident #2 calling out for help, LPN #2 ran down to the room, observed Resident #2 lying on the floor next to the bed with his/her head at the bottom of the bed, and notified the nursing supervisor, Registered Nurse (RN) #1. RN #1 identified Resident #2 was conscious, laying on his/her back on the floor next to the right side of the bed. RN #1 indicated Resident #2 had no injuries and denied any pain. RN #1 indicated he conducted a skin check and Resident #2 had no skin impairments. The nurse's note dated 7/20/2025 at 4:30 AM written by RN #1 identified he was notified by LPN #2 that Resident #2 was lying on the floor on the right side of the bed and Resident #2 was conscious and verbal. RN #1 indicated he assessed Resident #2, no injuries noted, and Resident #2 denied any pain. RN #1 identified Resident #2 denied hitting his/her head, and neuro checks were initiated. RN #1 indicated the Advanced Practice Registered Nurse (APRN) and Resident #2's responsible party were notified. The APRN note dated 7/21/25 at 1:20 PM written by APRN #1 identified she was asked to see Resident #2 following a fall incident in his/her room. The note indicated Resident #2 was stable and had no signs of acute distress, Resident #2's vital signs were within normal limits, Resident #2 denied any pain and denied hitting his/her head. The note identified neurological checks were initiated for seventy-two (72) hours and an order directed an X-ray of the pelvis and hip to further evaluate Resident #2. A physician's order dated 7/20/25 directed to obtain X-rays of pelvis and bilateral hips for general assessment. The radiology results report dated 7/20/25 at 9:37 PM identified the findings showed no fractures of the right hip, left hip, and pelvis. Review of the neurological evaluation flow sheet dated 7/20/25 directed to conduct neurological evaluations at the initial time of the incident, then every fifteen (15) minutes for the first two (2) hours, then every thirty (30) minutes for two (2) hours, then every hour for four (4) hours, and then every eight (8) hours for at least sixty-four (64) additional hours. The neurological evaluation flow sheet identified on 7/20/25 neurological evaluations were initiated at 2:50 AM, conducted every fifteen (15) minutes until 4:35 AM. On 7/20/25 at 4:50 AM, 5:20 AM, 5:50 AM, 6:20 AM and 6:50 AM, LPN #2 documented Resident #2 was asleep, and had stopped evaluating Resident #2's neurological status. The neurological evaluation flow sheet was completed again at 7:20 AM on 7/20/25 at 7:20 AM to 2:00 AM on 7/21/25 indicating Resident #2's neurological status was assessed. Interview with RN #1 on 8/21/2025 at 11:12 AM identified on 7/22/25 at approximately 2:50 AM, LPN #1 notified him Resident #2 had a fall and was lying on the floor in his/her room. RN #1 indicated when he entered the room Resident #2 was lying on his/her back on the floor next to the bed and Resident #2 was alert and responsive, denied hitting his/her head, denied any pain, and no injuries were noted. RN #1 identified he assessed Resident #2's neurological status, Resident #2's neuros were within normal limits, and initiated neuro checks. Interview with the 11PM-7AM nurse aide, Nurse Aide (NA) #4, on 8/21/25 at 11:19 AM identified on 7/22/25 at approximately 2:50 AM, LPN #2 yelled to her to come down to Resident #2's room, NA #4 identified when she entered the