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	09/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(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 - 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 policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were dependent on staff for transfers, the facility failed to ensure the appropriate number of staff, two (2), transferred the resident via a mechanical lift to prevent a minor injury. The findings include:Resident #1's diagnoses included morbid obesity, osteoarthritis to the right knee, gait abnormalities, and generalized muscle weakness. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits and was alert and oriented to time and situation, and was dependent on staff for turning and repositioning when in bed and transfers getting in and out of the bed and chair. The Resident Care Plan dated 6/27/25 identified Resident #1 had a self-care deficit and was at risk for falls due to gait abnormalities and muscle weakness. Interventions directed assistance of one (1) with bed mobility and assistance of two (2) with mechanical lift transfers. The resident care card identified Resident #1 was out of bed daily with the assist of two (2) for transfers via a mechanical lift. The nurse's note dated 8/16/25 at 11:35 AM identified when Resident #1 was transferred via the mechanical (Hoyer) lift by staff, the bar on the lift brushed up against Resident #1's nose and caused a light nosebleed. A body audit was conducted, no other injuries were identified, and vital signs were stable. The note identified the nursing supervisor and Advanced Practice Registered Nurse (APRN) were notified and the APRN directed a facial x-ray be done and every fifteen (15) minute neuro checks were initiated. The nurse's note dated 8/16/25 at 6:55 PM identified the 7AM-3PM nursing supervisor, Registered Nurse (RN) #1, assessed Resident #1 and did not identify any bruising to the face. The note indicated Resident #1 had referred to the Hoyer transfer as quite a ride and clarified the statement meant the sling of the Hoyer was swinging while he/she was in it. Resident #1 had explained he/she did not hit any metal part of the Hoyer but after feeling the Hoyer pad straps, Resident #1 felt based on the texture of the straps, he/she had hit the end of the loops of the straps. The note identified Resident #1 declined going to the hospital for x-rays and wanted to wait until the x-rays could be done at the facility and continuously stated he/she was fine. A written statement dated 8/16/25 by the 7AM-3PM nurse aide, Nurse Aide (NA) #1, who had been assigned to Resident #1 on 8/16/25, identified after he provided care, he decided to Hoyer lift Resident #1 on his own because all other nurse aides were providing care to other residents. NA #1 wrote doing the transfer, the sling slid over and snagged Resident #1's nose. The nurse's note dated 8/17/25 at 10:35 PM identified the x-ray results of the face and nose were normal. A physician's progress note dated 8/22/25 identified Resident #1 was accidentally hit by a strap from the Hoyer lift while being transferred. The note indicated Resident #1 denied fear; however, he/she had refused to get out of bed and this behavior may have been exacerbated due to the incident, and there was also a potential for increase in anxiety. The note indicated to continue to encourage Resident #1 to get out of bed and monitor. The facility's summary report dated 8/25/25 indicated Resident #1 was being transferred out of bed to the wheelchair. According to staff and Resident #1's interviews NA #1 transferred Resident #1 alone with the Hoyer lift and although there was another nurse aide in the room, NA #1 failed to ask the nurse aide for assistance. The report identified the transfer resulted in Resident #1 hitting his/her nose on the sling pad causing a bloody nose. The conclusion indicated NA #1 was terminated for not following the facility policy on safe resident handling and the use of the mechanical lift. Interview with the 7AM-3PM charge nurse, LPN #1, on 9/2/25 at 12:30 PM identified NA#1 was wheeling Resident #1 to the dining room when she noticed Resident #1's nose was bleeding and NA #1 was not aware of the nosebleed. LPN #1 explained Resident #1 had stated he/she had a rough ride and that he/she hit his/her nose on the Hoyer sling. LPN #1 identified NA#1 admitted , although another nurse aide was in the same room providing care to another resident with the curtains drawn, NA #1did not ask that nurse aide for help with the transfer of Resident #1 because he did not want to bother the other nurse aide. LPN #1 indicated the facility policy was that two (2) people were to transfer a resident with a Hoyer lift. Interview with Resident #1 on 9/2/25 at 12:50 PM identified he/she recalled the event when he/she got a bloody nose during a transfer. Resident #1 was able to express that a male transferred him/her on that day, and he was by himself. Resident #1 explained that two (2) people usually transferred him/her out of bed. Resident #1 denied any pain after and stated nothing was broken or bruised. Interview with the nurse educator, (RN) #2, on 9/2/25 at 1:30 PM identified she trained staff on the safe transfer policies and NA #1 had training in February 2025 with the annual staff training and then again on 7/7/25 and passed both trainings. RN #2 indicated the requirement of two (2) staff