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	10/16/2025

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 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. (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 0580 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 record review, facility documentation, and staff interviews for one of three residents (Resident #1), reviewed for accidents, facility failed to ensure staff failed to notify the Registered Nurse (RN) supervisor after Resident #1 sustained a fall. The findings include:Resident #1 had a diagnosis of schizophrenia, falls, dementia, and difficulty in walking. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) indicating severely impaired cognition, required maximum assistance for bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 8/28/2025 identified the resident needs assistance with activities of daily living and was a risk for falls. Interventions directed to ensure the bed was in the lowest position, call light within reach, and required assist of two (2) staff with a mechanical lift for transfers. Nursing note dated 10/3/2025 at 11 AM identified Resident #1 reported an unwitnessed fall during the night. Resident #1 had facial grimacing upon movement to the left arm and shoulder with bulging to left shoulder joint. No visible bruising or bleeding was noted. Resident #1 had no range motion of the shoulder and complained of pain to the left shoulder. The physician was notified, pain medication was given, and Resident #1 was transferred to the hospital for evaluation. Facility reportable event dated 10/3/2025 at 2:45 AM identified Resident #1 had dementia (BIMS 3), was non-ambulatory and required two (2) staff for transfers via mechanical lift. The report indicated Resident #1 fell while trying to get up from bed to get his/her shoes. Resident #1 complained of left arm and shoulder pain. Resident #1 was transferred to the hospital, and x-ray identified an acute mildly displaced fracture of the surgical neck of the left humerus (upper arm bone). Physician indicated Resident #1 was not a surgical candidate and was returned to the facility. The reportable event summary dated 10/8/2025 identified after the fall, the Nurse Aide (NA) picked his/her arm from the floor and placed back in bed. The resident was transferred to the hospital and diagnosed with a mildly displaced left humerus fracture. The NA was called via phone and admitted the resident had a fall and she picked the resident up and placed him/her in bed. The NA also admitted she did not report the incident to the charge nurse. The NA indicated she know to not move a resident from the floor without an RN evaluation and to report a fall. Interview with RN #1 on 10/16/2025 at 11:02 AM identified she was the supervisor during the night shift on 10/3/2025 and she did not know Resident #1 fell during the shift; she informed afterwards by management that NA #1 picked the resident up off the floor following a fall. RN #1 stated that NA #1 should have informed her the resident fell and she would have completed an RN assessment. Interview with NA #1 on 10/16/2025 at 11:16 AM identified at around 2:45 AM she went to answer a residents call light and when she walked by Resident #1's room she noticed Resident #1was on the floor next to his/her bed. Resident #1 asked NA #1 to put her/him back into bed. NA #1 stated she placed her left hand on the resident's back and her other arm under the resident's legs, and picked him/her up and into bed. NA #1 stated she did not notify the change nurse, the Nurse Aide assigned (NA #2) or the supervisor. NA #1 stated she should have notified the nurse when she observed Resident #1 on the floor. Interview failed to identify why NA #1 did not notify the charge nurse or supervisor that Resident #1 was on the floor. Review of Facility Falls Management Policy dated 5/1/24 directed a fall was considered to have occurred when a patient was found on the floor. Patients experiencing a fall will receive appropriate care. Interview and record review with the Administrator, Director of Nursing (DNS), and RN #2 on 10/16/2025 at 2:17 PM identified Resident #1 required use of a mechanical lift with two (2) staff for transfers. The DNS stated on 10/3/2025 during the 7 AM to 3 PM shift Resident #1 reported he/she had fallen about 2:45 AM and someone picked him/her up and placed him/her back in bed. The DNS stated the facility investigation identified NA #1 observed Resident #1 on the floor on 10/3/2025 about 2:45 AM and NA #1 picked Resident #1 up off the floor herself and did not notify the nurse or supervisor prior to moving the resident. The DNS stated she did not know why NA #1 did not notify the charge nurse or supervisor, and stated NA #1 should have notified the nurse and an RN assessment should have been completed prior moving Resident #1. Facility documentation review identified staff education was initiated on 10/3/2025 and included directing staff to report any fall incident immediately to the charge nurse or supervisor, and an RN assessment must be completed before the resident can be moved from the location of the fall. A QAPI meeting was held on 10/3/2025, and audits were initiated on 10/5/2025. Based on review of facility documentation, past non-compliance was identified.

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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation, and staff interviews for one of three residents (Resident #1), reviewed for accidents, facility failed to ensure the resident was transferred in accordance with the plan of care. The findings include:Resident #1 had a diagnosis of schizophrenia, falls, dementia, and difficulty in walking. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three (3) indicating severely impaired cognition, required maximum assistance for bed mobility and was dependent for transfers. The Resident Care Plan (RCP) dated 8/28/2025 identified the resident needs assistance with activities of daily living and was a risk for falls. Interventions directed to ensure the bed was in the lowest position, call light within reach, and required assist of two (2) staff with a mechanical lift for transfers. Nursing note dated 10/3/2025 at 11 AM identified Resident #1 reported an unwitnessed fall during the night. Resident #1 had facial grimacing upon movement to the left arm and shoulder with bulging to left shoulder joint. No visible bruising or bleeding was noted. Resident #1 had no range motion of the shoulder and complained of pain to the left shoulder. The physician was notified, pain medication was given, and Resident #1 was transferred to the hospital for evaluation. Facility reportable event dated 10/3/2025 at 2:45 AM identified Resident #1 had dementia (BIMS 3), was non-ambulatory and required two (2) staff for transfers via mechanical lift. The report indicated Resident #1 fell while trying to get up from bed to get his/her shoes. Resident #1 complained of left arm and shoulder pain. Resident #1 was transferred to the hospital, and x-ray identified an acute mildly displaced fracture of the surgical neck of the left humerus (upper arm bone). Physician indicated Resident #1 was not a surgical candidate and was returned to the facility. Emergency department physician note dated 10/3/2025 at 2:33 PM identified x-ray results indicated a proximal (close to the shoulder) humerus (upper arm bone) fracture, with a sling placed and plan for outpatient orthopedic follow-up. The reportable event summary dated 10/8/2025 identified after the fall, the Nurse Aide (NA) picked his/her arm from the floor and placed back in bed. The resident was transferred to the hospital and diagnosed with a mildly displaced left humerus fracture. The NA was called via phone and admitted the resident had a fall and she picked the resident up and placed him/her in bed. The NA also admitted she did not report the incident to the charge nurse. The NA indicated she know to not move a resident from the floor without an RN evaluation and to report a fall. Interview with NA #1 on 10/16/2025 at 11:16 AM identified at around 2:45 AM she went to answer a residents call light and when she walked by Resident #1's room she noticed Resident #1was on the floor next to his/her bed. Resident #1 asked NA #1 to put her/him back into bed. NA #1 stated she placed her left hand on the resident's back and her other arm under the resident's legs, and picked him/her up and into bed. NA #1 stated she did not know Resident #1's transfer status, and stated she did not know why she transferred the resident without knowing the residents transfer status. NA #1 stated she should have checked the residents transfer status prior to transferring resident. Interview and record review with the Director of Rehabilitation on 10/16/2025 at 1:35 PM identified Resident #1's transfer status required the use of a mechanical lift with an assistance of two (2) staff. The Director of Rehabilitation stated if Resident #1 was on the floor, one (1) staff member should not lift the resident off the floor and instead should use a mechanical lift with the assistance of two (2) staff. Interview and record review with the Administrator, Director of Nursing (DNS), and RN #2 on 10/16/2025 at 2:17 PM identified Resident #1 required use of a mechanical lift with two (2) staff for transfers. The DNS stated on 10/3/2025 during the 7 AM to 3 PM shift Resident #1 reported he/she had fallen about 2:45 AM and someone picked him/her up and placed him/her back in bed. The DNS stated the facility investigation identified NA #1 observed Resident #1 on the floor on 10/3/2025 about 2:45 AM and NA #1 picked Resident #1 up off the floor herself; NA #1 did not call for assistance or use a mechanical lift for the transfer. Interview identified NA #1 1 transferred Resident #1 back into bed alone, by placing one hand on the resident's back and the other under the resident's legs and scooped him/her up and placed Resident #1 back into bed. The DNS stated she did not know why NA #1 did not transfer Resident #1 per the care plan and indicated a mechanical lift should have been used to transfer the resident back into bed after an RN assessment was completed. Review of Facility Falls Management Policy dated 5/1/24 directed a fall was considered to have occurred when a patient was found on the floor. Patients experiencing a fall will receive appropriate care and be evaluated for injury and a total lift will be used to lift patients off the floor. Facility documentation review identified staff education was initiated on 10/3/2025 and included directing ensure residents were transferred