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	05/13/2025

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident # 71), reviewed for Preadmission Screening and Resident Review (PASARR), the facility failed to ensure a newly identified mental health diagnosis was referred to appropriate state- designated mental health authority for a level 2 evaluation. The findings include: Resident #71's diagnoses included schizoaffective disorder, mild cognitive impairment and delusional disorder. Review of Resident # 71 clinical records indicated identified a Level II was done on April 13, 2022, with a qualified diagnosis delusion. Further review of Resident #71 clinical records indicated a new diagnosis of schizoaffective was identified on 10/8/23. However, there was no evidence of a referral submitted to the appropriate state- designated mental health authority for a level 2 evaluation. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated the resident was severely cognitively impaired. Resident #71 was noted independent with eating, bed mobility and personal hygiene. The resident's mood and behavior were unable to be assessed. The care plan dated 4/10/25 identified Resident #71 exhibits psychosocial distress with own well-being and/or social relationships related to: Illness/Disorder/Disease process: hallucinations delirium, mental retardation/developmental disability, use of antipsychotic medication. Interventions included to evaluate need for psychiatric/ behavioral health consult and document frequency and impact of the behaviors. Interview with Social Worker (SW #1) on 5/7/25 at 1:50 PM identiifed she would be informed by the psychiatry or the nursing team if there is a new diagnosis or change in condition (related to mental health). Social Worker #1 reported, given Resident #71 was long term care resident who has a history of a level II evaluation, she was not aware that a new referral had to be submitted for new mental health diagnosis. Facilities Social Services Policies and Procedure (Pre-admission Screening for mental Disorder and/or Intellectual Disability Patients) indicates in part, Notify the state mental health authority as applicable promptly after a significant change in mental or physical condition of a patient who has a mental disorderfor review.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility policy and staff interviews for 1 of the 3 residents reviewed for Activities of Daily Living (ADL) for (Resident #111), the facility failed to ensure the resident consistently received scheduled showers. The findings include: Resident #111's diagnoses included Guillain-Barre Syndrome (a neuromuscular disease) and muscle weakness. The care plan dated 4/29/2025 identified Resident #111 required assistance to perform activities of daily living, such as bathing and grooming, related to limited mobility. Interventions included helping with transfers with a rolling walker. The quarterly MDS assessment dated [DATE] identified Resident #111 was cognitively intact and required partial/moderate assistance for bathing/showering and partial/moderate assistance for transferring to and from the tub/shower. On 5/6/2025, an interview with Resident #111 indicated his/her shower day was Wednesday on the 3:00 PM to 11:00 PM shift. The resident indicated she/he had missed two showers on 4/23/2025 and 4/30/2023. Resident # 111 further indicated staff had told him/her the day staff were too busy to provide her/him with a shower. Additionally, Resident #111 recalled she/he had spoken to Nurse Aide (NA#3) regarding the missing showers. Resident #111 further indicated NA#3 recommended the resident notify the unit manager (RN#6). A review of Nursing Aide medical record documentation for bathing from 4/15/25 through 5/10/25 identified Resident #111 had one documented shower on 5/9/2025. Resident # 111 received bed baths on 4/15, 4/18, 4/22, 4/25, 4/29, 5/2, 5/6, and 5/9/2025. There was no documented bath or shower for 4/23 or 4/30/ 25 when the resident's shower day was scheduled. On 5/12/2025 at 11:11 AM, an interview with NA#1 indicated she recalled showering the resident on 5/9/2025 and indicated the week prior (4/30/2025), she had not showered the resident. NA#1 indicated she offered the resident a shower between 3:00 PM and 4 :00 PM, but the resident had requested a later shower. NA#1 further identified the resident requested the shower at 9:30 PM. NA#1 further indicated that at that time it was too late for a shower because the resident was an assist of two staff member to get up from the bed and shower. Na #1 also indicated all staff members were busy during that time of Resident # 111 request. NA#1 further indicated the resident complained to her (NA# 1) that she/he had missed a shower day when NA#1 was off but could not recall the date. NA#1 indicated when a resident receives showered, nurse aides document the shower in the medical record. On 5/12/2025 at 11:45 AM, an interview with the NA taking care of Resident #111 for the day (NA#2) identified Resident #111 complained to him that she/he had not received a shower the week of April 28 but could not recall the exact date. NA#2 indicated that he notified RN#6 about the resident's complaint. NA#2 indicated he was not aware of the outcome of the resident's complaint. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/2025 at 12:00 PM, an interview and record review with RN #6 identified she had been notified of the resident's complaint. RN#6 indicated she had not yet spoken to NA#1 (who had been caring for Resident #111) but had spoken to another nurse aide on the 3 :00 PM to 11 :00 PM shift that provided showers to Resident # 111. RN#6 indicated the resident has psychiatric diagnoses that may contribute to the resident thinking she/he did not get showered. RN #6 was not able to identify why the shower documentation in the medical record failed to identify that showers were given. RN # 6 also indicated that the expectation was that nurse aides document the resident shower in the electronic medical record. On 5/12/2025 at 12:39 PM, an interview with NA #3 indicated Resident #111 had complained to him that she/he had not received a shower. NA #3 indicated that he later spoke to NA #1 and NA #1 had assured him Resident # 111 had been getting showers. NA #3 was unable to recall when Resident #111 had complained of not getting a shower. NA #3 further indicated that showers are documented in the computer by the nurse aides. On 5/12/2025 at 12:45 PM, a review of nursing progress notes from 4/22/2025 through 5/9/2025 and the behavior monitoring from 4/1/2025 to 4/30/2025 failed to identify behaviors of care refusal or psychotic behaviors that would have contributed to the resident not receiving showers. The facility policy for Activities of Daily Living given onsite notes documentation of ADL care is recorded in the medical record and must be reflective of the care provided by nursing staff. The policy also indicated that ADL care must be documented in real time, as close to the time that care was provided.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review clinical record reviews, observation, facility documents, review of policy and interviews for 1 of 4 residents reviewed for accidents (Resident #38), the facility failed to ensure a physician order was written for a diagnostic x-ray after a fall and for 1 of 1 resident reviewed for positioning (Resident #271), the facility failed to ensure the resident's cervical collar was positioned appropriately. The findings included: 1.Resident #38's diagnosis included dementia with behavioral disturbance and repeated falls. The annual MDS assessment dated [DATE] indicated Resident #38 was severely cognitively impaired, had 2 or more falls since prior assessment with no injury, no impairment of the upper and lower extremities and utilized a walker with supervision or touch assist to walk 10 feet once standing. The care plan in place on 7/30/2024 indicated Resident #38 was at risk for falls due to cognitive loss and lack of safety awareness. Interventions included: provide verbal cues for proper pacing and provide a clutter-free environment in the room, obtain psychiatric evaluation for increased agitation during the evening, when the resident attempts to stand unassisted, to provide cues to sit down and wait for assistance and noted the utilization of a wheelchair for safety due to not safe to ambulate independently with a walker. A nursing progress note dated 8/23/2024 at 05:47 PM indicated the Registered Nurse (RN) was called to the unit as Resident #38 fell after eating dinner when she/he attempted to stand. The RN indicated Resident #38 complained of pain in the right thigh, was assessed by the RN and placed in the wheelchair and transported to his/her room. The note further indicated that the Advanced Practiced Registered Nurse (APRN) was notified who then ordered an x-ray of the right hip and thigh and the Power of Attorney was notified. A nurse's note dated 8/23/2024 at 4:16 PM indicated in part, the responsible party was notified and informed an x-ray of the right thigh would be completed. The Radiology Report results for an x-ray of the femur 2 views was reported to the facility on 8/24/2024 at 9:11 AM (x-ray obtained on 8/23/2024 at 9:10 PM) indicated no acute fractures or dislocations, the femoral head and neck were intact if symptoms persist consider a follow up x-ray as clinically warranted. On 8/24/2024 at 7:02 PM a Nurse Practitioner telehealth notification note indicated the hip x-ray was negative for fracture. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and verbal review of the clinical record with APRN #1 on 5/13/2025 at 11:40 AM with the ADNS and DNS present indicated s/he no longer worked at the facility and had no access to clinical records. APRN #1 further indicated she/he could not recall what type of x-rays were ordered at the time of the fall and cannot recall the hip x-ray was completed only a femur x-ray. The DNS indicated the nursing notes dated 8/23/2024 identified a hip x-ray and a femur x-ray were ordered by the provider (APRN#1) and a note contacting the responsible party about Resident # 38's x-ray of the thigh would be completed. However, the two notes indicated different x-rays, but the physician order (never written) would have clarified what was ordered. The DNS further indicated the femur x-ray completed indicated the femoral head and neck were intact. The DNS also indicated a physician's order for the type of x-ray was not written. A facility policy labeled Physician/Advanced Practice Provider Orders reviewed and revised on 3/01/2022 indicated the facility policy is to ensure all physician orders were received from a credentialed practitioner before implementing. The policy further indicated that the licensed person taking the order must enter the physician's order into the electronic order management system. A Facility policy labeled Transcription of Orders reviewed and revised on 5/01 2023 indicated in part, transcribing is the recording of physician's orders obtained from a provider by an RN or Licensed Practical Nurse (LPN). 2. Resident #271 was admitted on [DATE] with diagnoses that included a cervical spine fracture and a brain bleed. The admission nursing assessment dated [DATE] identified Resident #217 was alert and oriented to self and place but not to time. The assessment also noted the resident as slightly limited in mobility. A physician's order dated 4/23/2025 directed to maintain cervical collar at all times and noted may be removed for care as needed until 7/23/2025. A care plan dated 4/23/2025 indicated Resident #271 had a self-care performance deficit related to a fracture of the cervical spine. Intervention included assisting to turn and reposition in bed. On 5/5/2025 at 1:20 PM, Resident #271's rigid cervical collar was observed to be inappropriately positioned, with the chin piece, which is usually positioned under the wearer's chin, on the resident's chin, right under the resident's lower lip. The front piece, which is usually positioned on top of the wearer's chest, was floating over the wearer's chest. On 5/5/2025 at 1:30 PM, an observation and interview with LPN #4 indicated that was how the resident's collar was supposed to fit since that is how it had always been placed. LPN #4 also indicated that the collar is removed for care and the last time she removed collar was on 5/5/2025 at 8:30 AM to inspect the skin. LPN#4 also indicated that physical therapy had provided staff with an in-service when the resident first arrived at the facility, but that she did not work that day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/2025 at 2:44 PM an observation and interview with the Director of Physical Therapy (PT#1) identified Resident #271's collar was not appropriately positioned and PT #1 observed that the resident's chin piece was on the resident's chin close to the lower lip and the front piece was again floating over the resident's chest instead of directly on the resident's chest. PT #1 indicated that the collar was not positioned appropriately and proceeded to adjust Resident #271's collar to the correct position. A review with PT#1 of the resident's Physical Therapy Evaluation dated 4/24/2025 identified PT#1 had educated the resident and the staff on appropriate collar alignment. PT#1 further indicated that he had educated the staff who were on shift that day, including the unit manager. PT #1 also indicated Resident #271 receives physical therapy and occupational therapy, and the resident had received occupational therapy on 5/6/2025. On 5/7/2025 at 9:51 AM, an interview with Occupational Therapist (OT#1) indicated she had provided occupational therapy to the resident on 5/6/2025 after lunchtime around 1:30 PM or 2:00 PM. OT#1 indicated the resident moves the collar and she provided education to the resident. OT#1 indicated that when she left the resident on 5/6/2025, the collar was appropriately positioned. OT#1 did not recall if she had provided education to nursing staff regarding the resident's collar position. A review of the resident's care plan and nursing progress notes from 4/28/2025 through 5/7/2025 failed to identify instances where the resident was noted to be moving the cervical collar or behaviors that would contribute to inappropriate collar alignment. After surveyor's inquiry, a care plan dated 5/7/2025 identified that Resident #271 was resistant to care related to the cervical collar, with interventions including checking the collar placement and reiterating the importance of keeping the collar properly in place as directed per plan of care. The facility policy for Cervical Collar Application dated 5/1/2023 indicated that a wearer's chin must fit into the indentation on the front aspect of the collar.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility policy and staff interviews for the only resident reviewed for Pressure Ulcer (Resident #99), the facility failed to ensure a physician order was obtained for mattress setting for a specialty mattress and failed to ensure licensed staff checked the settings per the facility policy. The findings include. Resident #99s diagnosis include dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #99 was severely cognitive impairment and a stage 3 pressure ulcer that was not present on admission. The care plan dated 4/15/2025 indicated in part Resident #99 was at risk for skin breakdown due to impaired cognition, incontinence, limited mobility, poor safety awareness and noted a Stage 3 pressure ulcer of the right trochanter. Interventions included: to provide a pressure redistribution surface to the chair and bed, to provide wound treatments as ordered and to reposition 4 times per shift. An observation on 5/5/25 at 12:23 PM noted Resident #99 in bed with an air mattress on the bed with the setting halfway up from soft. On 5/7/25 at 12:13 PM during an interview and record review with LPN #1 indicated the physician would write a physician's order then staff would set up the air mattress based on the resident's weight. However, LPN # 1 was unable to locate a physician order for the air mattress or any instructions for the settings and monitoring of the mattress. An interview and record review and facility policy review with the Director of Nursing Services (DNS) on 5/7/25 at 1:30 PM indicated s/he would have expected a physician order for the mattress along with settings and the nursing staff is responsible for monitoring the mattress. The facility policy labeled Specialty Mattress Replacement surfaces: Use of indicted in part a resident would be evaluated to determine the need for placement of, or the utilization of a specialty mattress and a physician's order will be obtained. The policy further indicated the settings would be adjusted to the manufactures settings by nursing, settings would be checked by a licensed nurse, and the bed kept in the low position when a resident was unsupervised.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, facility policy review and staff interview for 1 of 4 residents (Resident #117) reviewed for nutrition, the facility failed to ensure weights were obtained per facility policy for a resident with weight loss. The findings include. Resident #117's diagnosis included obesity, dysphagia and aphasia. The electronic documentation section labeled vital signs/weights indicated on 3/4/2025 noted Resident #117 weighed 155.0 pounds. The electronic documentation section labeled vital signs/weights indicated on 4/13/2025 Resident #117 weighed 147.6 pounds (6.4 pounds weight loss in 39 days and no re weight obtained to verify the weight loss). The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #117 had severe cognitive impairment, held food in mouth cheeks, weight was 148 pounds with no loss or gain of 5% in the last 30 days or 10% in the last 6 months, and noted the resident was on a mechanically altered diet. The care plan dated 5/6/2025 indicated in part Resident #117 was at risk for nutrition and hydration changes related to a mechanically altered diet, variable oral intake, dysphagia significant weight loss and obesity. Interventions included: to monitor for signs of malnutrition, holding food in the mouth, refusing to eat, difficulty swallowing, to monitor/report and record notification of the physician if Resident #117 had lost 3 pounds in a week, greater than 5% weight loss in one month, 7.5% in 3 months or 10% weight loss in 6 months and to obtain weight as ordered. A physician's order dated 4/24/2025 directed to obtain a weight on the 7-3 PM shift every Friday for 4 weeks. A physician's order dated 4/24/2025 directed to obtain weight on the 7-3 PM shift monthly during the first 5 days of the month. Resident #117 was readmitted to the facility from the hospital on 4/24/2025. A Nutritional assessment dated [DATE](4 days after readmission) indicated Resident #117 had been readmitted after a hospitalization with noted weight loss of 4.8% since 3/4/25 and triggered for a 5.5% weight loss from 3/4/25-4/11/25. A readmission weight was requested from nursing staff. Recommendations included 120mls of house supplement twice daily and to obtain a readmission weight. The electronic documentation section labeled vital signs/weights indicated on 4/30/2025 at 8:26 AM Resident #117 weighed 140.0 pounds (7.4 pounds within 29 days and readmission weight was obtained 6 days after readmission to the facility and 2 days after the dietician requested the readmission weight be obtained). No weight was documented as obtained to verify the weight loss. On 5/9/25 at 12:48 PM an interview and record review with the unit manager RN #6 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated she/he did not know why a weight for the resident was not completed on readmission and reweights were not taken when weights were noted to be 5 pounds or greater less. RN #6 further indicated s/he had monitored the weights monthly after the monthly weights are obtained the first week of the month and did not look at the weights after when residents were readmitted from the hospital. RN # 6 further indicated she/he would look at results for residents with specific orders for daily or weekly weights. RN #6 further indicated not being able to find any documentation of the weight loss or that the physician was notified. After surveyor inquiry, RN # 6 indicated s/he would notify the physician and write a nursing note (26 days after the 6.4-pound weight loss noted on 4/13/2025 and 9 days after the 7.4-pound weight loss was noted on 04/30/2025). The facility policy labeled Monitoring Weights dated 4/09/2025, indicated in part resident weights are obtained within 48 hours of admission and readmission then weekly for 4 weeks. The policy further indicated that residents with an unplanned weight loss/gain of 5 pounds or more must be reweighed within 24 hours and a significant gain or loss of weight must be 1. Documented by nursing in the nursing progress notes 2. The care plan adjusted/revised accordingly. 3. Notification to the physician of the loss /gain 4. Refer to Dietician and the DNS for review.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of employee files, facility documentation for skills competency and interview for 1 licensed staff (LPN # 8), the facility failed to ensure licensed staff completed clinical competency validations to provide nursing and related services to meet the residents' needs safely for the year 2024. The findings include:. A review of LPN #8's personnel file identified the date of hire as 5/23/23. However, the employee file failed to identify that Clinical Competency Validations were completed for the year 2024 for LPN # 8 and other licensed staff members. The Facility assessment dated [DATE] identified in part, employee competency assessment and education are an integral part of maintaining proper care of Residents. Staff should possess a clear understanding of their scope of practice and the duties they are responsible for daily. Interview with the Director of Nursing Services (DNS) on 5/13/25 at 11:30 AM identified no licensed staff received clinical competency validations for the year 2024. The DNS further indicated the former Staff Development employee, who was responsible for conducting the competency validations, did not complete them prior to leaving the organization. The DNS also identified that moving forward, the Assistant Director of Nursing Services (ADNS) will assume responsibility for conducting clinical competency validations. A policy for clinical competency validations for licensed staff was requested but not provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and interviews for 4 of 5 residents reviewed for Unnecessary medication review (Residents #22, # 32, 58 and #86), the facility failed to ensure monthly pharmacy reviews were consistently completed. The findings included: 1. Resident #22's diagnosis included end stage renal failure, anxiety, major depression, thrombosis and gastrointestinal bleed. The care plan dated 2/10/2025 indicated Resident #22 was at risk for complications related to the use of psychotropic drugs. Intervention included having a gradual dose reduction as ordered, to monitor for side effects and consult physician and/or pharmacist as needed, and to monitor medications, especially new/changed/discontinued, for side effects and resident's/patient's response contributing to verbal behaviors The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident 322 was cognitively intact, taking antipsychotic, antianxiety, antidepressant, opioid, antiplatelet and anticonvulsant medications. On 5/12/25 at 10:30 AM an interview, review of the clinical record and facility documentation with the DNS identified monthly pharmacist regimen reviews had been completed for 5/2024 and 6/2024 and 1/2025. The Director of Nursing Services (DNS) indicated May 2024, and June 2024 was prior to his/her start of employment at the facility in 8/2024. The DNS indicated the change in ownership consisted of a change in pharmacy companies and the person in charge at the time did not know the new pharmacy did not provide pharmacy consultants monthly for medication regimen reviews for each resident. The DNS indicated she/he would look for the 1/2025 monthly pharmacy review, but none were found. 2. Resident #32's diagnoses included unspecified dementia, schizophrenia and major depressive disorder. The care plan dated 3/5/25 identified Resident #32 is at risk for complications related to the use of psychotropic drugs. Interventions included: obtaining Abnormal Involuntary movement (AIMS) testing per protocol, gradual dose reduction as ordered, monitor for changes in mental status, functional level, effectiveness and for any adverse effects and report to the Medical Doctor (MD) as indicated. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was cognitively impaired and noted dependent for personal hygiene and oral hygiene care. The MDS also indicated Resident #32 was receiving antipsychotic medication on a routine basis. Review of clinical records identified no monthly medication regimen review was completed on 5/20/2024 for Resident # 32. Interview with the DNS on 5/12/25 at 10:30 AM indicated the facility switched pharmacy providers and the replacement pharmacy company did not have pharmacy services causing no pharmacy reviews for May 2024. She also could not explain why the other months did not have any pharmacy consultations. (continued on next page)

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	05/13/2025

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #58's diagnoses included Type 2 diabetes mellitus, Chronic Obstructive Pulmonary Disease (COPD) and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 58 as cognitively impaired and required substantial assistance with personal and oral hygiene. MDS also indicated the residents were receiving antipsychotic medications, anti-diabetic, anticoagulant, diuretic, opioids and other forms of medications. The care plan dated 3/26/25 identified Resident #58 is at risk or complication related to the use of anticoagulation therapy medication. Interventions included laboratory blood work as ordered, anticoagulant to be given as ordered etc. Review of clinical records identified no monthly medication regimen review was completed on for January 2024 and May 2024 for Resident # 58. Interview with the DNS on 5/12/25 at 10:30 AM indicated the facility switched pharmacy providers and the replacement pharmacy company did not have pharmacy services causing no pharmacy reviews for May 2024. She also could not explain why the other months did not have any pharmacy consultations. Facilities Consultant Pharmacy Provider requirement policy indicates in part Reviewing medication administration records, treatment administration records and physician orders (at least monthly). This monthly review is documented in the patients' medical record. 4. Resident #86's diagnosis included cerebral infarction, seizures, kidney failure and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was severely cognitively impaired, noted no behaviors, utilization of antipsychotic, antidepressant hypoglycemic and antiplatelet medications. The care plan dated 3/21/2025 indicated Resident # 86 Resident is at risk for complications related to the use of psychotropic drugs. Interventions included in part to monitor for side effects and consult physician and/or pharmacist as needed. An interview and record review with the DNS on 5/8/2025 at 1:05 PM indicated the pharmacy regimen reviews were found in a binder all were present except 5/2024 and 6/2024. On 5/12/2025 at 10:30 AM the Director of Nursing Services (DNS) indicated May 2024 and June 2024 she/he was unable to provide the missing reports.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations of the facility Medication Storage and labeling, facility policy and interviews reviewed for 2 of 3 (1 North and 2 South Units) medication rooms, the facility failed to ensure that an expired medication was discarded. The facility failed to ensure the fridge temperatures were consistently checked and documented and failed to ensure that refrigerators were locked, utilizing locks. The findings included: 1. Observation on 5/13/25 at 10:15 AM of the medication room on 1 north identified the medication refrigerator containing medication was not securely locked with a padlock. Interview with RN#2 indicated she was just in the medication room and must have forgotten to lock it. After inquiry, the lock on the medication refrigerator was secured. 2.Observation on 5/13/25 at 10:37 AM of medication room on 2 South identified an Ear wax Removal Drop had expired on 11/13/24, stored in the medication room. Interview with RN#5 on 5/13/25 at 10:37 AM indicated the medication should have been discarded once the residents was no longer at the facility. RN#5 identified the nursing staff is responsible for going through and checking the medication rooms weekly for expired medications. She also indicated the ear wax removal must have been missed in error. 3. Observation on 5/13/25 at 10:52 AM of 2 South medication room identified missing temperatures/signatures for the refrigerator temperature logs. Missing dates were as follows: For the month of May 2025 (5 days), For the month of April 2025 (20 days) for the month of March 2025 (25 days), February 2025 (23 days) and January2025 (10 days) where refrigerator temperatures were not checked and signed off on. Interview with RN#5 and LPN #3 on 5/13/25 at 10:52 AM identified the temperature logs should completed daily on the 11-7 AM shift. They could not explain why this is not being done. 4.Observation on 5/13/25 at 10:57 AM of the refrigerator on 2 South medication room unlocked. Interview with LPN#3 on 5/13/25 at 10:57 AM indicated the lock was broken, therefore they were unable to use the padlock to close the refrigerator (which was storing medications). LPN #3 was unsure how long the lock had been broken. After the inquiry, the maintenance department was informed of the broken lock. Facilities Medication Storage policy indicated in part, Temperatures will be checked daily to ensure, it is the specified. Policy further indicates expired medications will be removed from the medication storage areas and disposed of in accordance with facility policy.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations of the dining, facility policy and interviews, the facility failed to ensure meals were served at the appropriate temperature. The findings include: Observation on 5/08/25 at 8:20 AM of food trucks leaving the kitchen. Observation on 5/08/25 at 8:20 AM of the food truck arriving at 2 North unit. Further observations identified dietary trays being passed out by all staff members. Observation on 5/08/25 at 9:06AM of the last resident on Unit 2 North being served (resident dining in the room). Food items leaving the kitchen were noted at the following temperatures: pureed eggs 200 degrees, pureed hash brown 198 degrees and pureed bread 182 degrees). However, during a test tray on 5/8/25 of the breakfast meal identified the following temperatures pureed hashbrowns were 110.1 degrees, pureed bread 106-degrees, pureed eggs were 106.3 degrees, (these food items left the kitchen at the following temperatures: pureed eggs 200 degrees, pureed hash brown 198 degrees and pureed bread 182 degrees). Interview with the Food Service Director on 5/08/25 at 9:06 AM identified the expectation is that meals are served warm. He further indicated the temperatures obtained were not considered warm enough for consumption. He also identified 135 degrees is acceptable for hot food temperatures and anything below that would need to be reheated Interview with DNS on 5/12/25 at 11:47 AM identified residents in the dining room and on the floors should be served warm food. The DNS also indicated that once the food trucks arrive on the unit, the food trays should be immediately distributed to the residents. She also indicated she believes the organization of the trays and delivery of the food trucks should be taken into consideration prior to leaving the kitchen to assist with efficient passing of the trays. The DNS expressed her suggestions to the kitchen staff after inquiry. The Facilities Food and Nutrition Dietary Services and Procedure policy indicates in part, Each resident shall receive, and facility should provide food and drink that is palatable and at a safe and appetizing temperature.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and staff interviews for 2 of 5 residents reviewed for (Residents # 26 and # 58) reviewed for vaccinations, the facility failed to obtain an influenza vaccine consent or refusal from the resident's responsible party. The findings include: 1 Resident #26 was admitted to the facility with diagnoses that included [NAME] encephalopathy (a severe neurological condition caused by a Vitamin B1 deficiency). An annual MDS assessment dated [DATE] indicated Resident #26 had severe cognitive impairment A care plan reviewed on 4/14/2025 indicated Resident #26 had a court-appointed conservator with interventions that included involving the conservator in care planning. On 5/7/2025 at 11:50 AM during record review and interview with the facility Infection Preventionist (LPN#5) identified Resident #26's Conservator of Person (COP) had consented to yearly influenza vaccination on 9/25/2023. The resident's immunization record identified that on 10/3/2023, the resident refused the influenza vaccine. The immunization record failed to indicate if the resident had received or been offered the influenza vaccine for the 2024-2025 season. An interview with LPN#5 identified Resident #26's COP had changed in November of 2024 and that neither consent nor refusal had been obtained from the new conservator. 2. Resident #58'S diagnoses included bipolar disorder and dementia. An MDS assessment dated [DATE] indicated Resident #58 had severe cognitive impairment. A care plan reviewed 4/29/2025 indicated Resident #58 had a court-appointed conservator with interventions that included involving the conservator in care planning. On 5/7/2025 at 11:50 AM during record review and interview with the facility Infection Preventionist (LPN#5) identified Resident #58 had given consent for influenza immunization on 9/29/2023. The resident's immunization record identified that on 10/4/2023, the resident received the influenza vaccine. The immunization record failed to indicate if the resident had received or been offered the influenza vaccine for the 2024-2025 season. An interview with LPN#5 identified Resident #58 was self-responsible in October 2023 and then was assigned a Conservator of Person (COP) in November 2023, and that neither consent nor refusal had been obtained from the conservator for the 2024-2025 influenza season. LPN#5 indicated that emails were sent in October 2024 for COP and Power of Attorneys to contact the facility to provide consent for the influenza vaccine. The facility then sent another email in December 2024 with education and consent forms to designated contacted people. LPN #5 further indicated that she received an email from Resident #58's conservatory requesting a list of all the residents conserved by them who reside at the facility to provide consents. LPN#5 indicated that she had not sent a list back to the conservator since the list dated 2/17/2025 had not been updated.