

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Monsignor Bojnowski Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 50 Pulaski Street New Britain, CT 06053	

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 - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460</p> <p>Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for two of three residents (Resident #1, #2) reviewed for accidents, the facility failed to ensure the residents were transferred in accordance with the plan of care to prevent an injury. The findings include:</p> <p>a. Resident #1's diagnoses included osteoarthritis, non-thrombocytopenia purpura, and dermatitis.</p> <p>Review of the Nurse Aide (NA) care card dated 7/23/2024 directed transfers with assist of one (1), device needed walker.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fourteen out of fifteen, indicative of no cognitive impairment and required partial/moderate assistance with transfers. The Resident Care Plan (RCP) dated 10/24/2024 identified Resident #1 had arthritis and required assistance with transfers. Interventions directed to transfer per MD orders and use of supportive devices as recommended.</p> <p>Physician order dated 12/2/2024 assist of one (1) with rolling walker and gait belt.</p> <p>Review of facility Reportable Event Form dated 12/28/2024 at 8:30 PM identified Resident #1 was alert and oriented, and transferred with one staff assist and a rolling walker. Resident #1 was being transferred from the wheelchair to bed and during the transfer his/her leg grazed over the metal part of the wheelchair for the attachment of the leg rest. Resident #1 sustained a right shin laceration measuring 6.5 by 3.5 centimeters (cm), was transferred to the hospital and required seven (7) sutures.</p> <p>Review of facility Summary Report dated 1/3/2025 identified NA #1 did not use the proper transfer and use of a rolling walker. The Summary indicated NA #1 did not use a walker for the transfer and the resident's feet were placed slightly under the wheelchair (not in front of the wheelchair) near the chair's metal bars when NA #1 stood the resident for the transfer. The Summary indicated use of a rolling walker and proper foot placement would have prevented the injury.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation on 1/14/2025 at 10:45 AM with Resident #1 identified his/her wheelchair had detachable leg/footrests. Resident #1 stated the area that caught and injured his/her leg was the upper thin metal flange on the inner side of the wheelchair that the detachable footrest (when attached) glides along when the leg rest is put in place for resident leg rest use. Resident #1 stated as the NA assisted with the transfer, his/her leg got caught on the area.</p> <p>Interview and record review with NA #1 on 1/14/2025 at 11:02 AM identified when she attempted to transfer Resident #1 from the chair to bed, Resident #1 yelled my foot, my foot. NA #1 stated Resident #1's legs were under the chair in a bended position when she started the transfer. NA #1 further stated she did not know Resident #1 required use of a walker, and she did not look at the NA care card for any needs Resident #1 may have required. NA #1 stated Resident #1 was calm during the transfer and did not direct NA #1 to use a walker. NA #1 stated after the transfer she learned she should have used a walker (stated it was the second time she worked at the facility).</p> <p>Interview, clinical record review and facility documentation review with the DNS and Administrator on 1/14/2025 at 1:51 PM identified on 12/28/2024 when NA #1 transferred Resident #1 from the wheelchair to bed she did not follow the care card. The DON stated the injury could have been prevented, and NA #1 should have used a rolling walker for the transfer as directed on the NA care card.</p> <p>b. Resident #2's diagnoses included Alzheimer's disease. The admission MDS assessment dated [DATE] identified that Resident #2 had a BIMS score of ten out of fifteen, indicative of moderate cognitive impairment and required substantial/maximal assistance with transfers. The RCP dated 8/21/2023 identified cognitive loss/dementia, and arthritis. Interventions directed offer one step at a time directions and consult with PT/OT as needed for any changes in transfer ability, positioning needs and use of supportive devices as recommended, transfer with caution, per transfer status and remind to use caution and be aware of the position of extremities when transferring and ambulating.</p> <p>Review of the NA care card dated 8/21/2023 directed transfer assist of two (2), device needed walker.</p> <p>Review of facility Reportable Event Form dated 9/2/2023 at 9 PM indicated Resident #2 was alert, confused and required two (2) staff for transfers with rolling walker/grab bar. Two (2) NAs were transferring Resident #2 from the chair to bed when Resident #2 sustained a skin cut to the left lower leg and was sent to the hospital. Resident #2 returned with stitches.</p> <p>Review of facility Summary Report dated 9/8/2023 identified Resident #2 had frail skin with purpuras (reddish - purple skin discoloration caused by bleeding under the skin). The Summary indicated the NAs failed to use the rolling walker per the physical therapy orders, and while the resident was pivoting for the transfer, his/her leg got caught in the side rail and caused a laceration. Both NAs were provided education regarding how to properly transfer Resident #2.</p> <p>Interview and observation on 1/16/2025 at 9:59 AM with DNS identified Resident #2 sustained a left leg injury on 9/2/2023 during the transfer with NA #2 and #3. The injury was caused from the release button on the side rail attached to the resident's hospital bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with NA #2 on 1/16/2025 at 10:21 AM identified the NA care card was not located on the closet door so she asked the nurse how to transfer Resident #2 and was told transfer with assist of two (2) staff. NA #2 stated she stood to the side of Resident #2 during the transfer with NA #3, and then Resident #2's leg got caught on the bed railing. NA #2 further stated she did not know she should have used a walker for the transfer.</p> <p>Interview and record review with NA #3 on 1/16/2025 at 10:54 AM identified she assisted NA #2 to transfer Resident #2. NA #3 stated she stood behind the wheelchair and after Resident #2 was standing, she moved to the side of Resident #2 and he/she shuffled and pulled himself, and plopped down on the bed. NA #3 stated she and NA #2 did not actually have hands on to assist Resident #2 with the transfer. NA #3 further stated she and NA #2 did not use a walker for the transfer, and the walker was not listed on the care card. NA #3 further clarified, both NAs were present for the transfer but did not give any physical assistance; Resident #2 transferred him/herself.</p> <p>During an interview, clinical record and facility documentation review with the DNS on 1/16/2025 at 1:29 PM with DNS stated the facility investigation identified NA #2 and #3 did an incorrect transfer; the NAs should have followed the care plan/care card as directed and should have used the rolling walker to transfer Resident #2.</p> <p>Review of the facility Safe Resident Handling/Transfers policy directed in part, to ensure that residents are handled and transferred safely to prevent or minimize risks for injury. Handling aids may include rolling walkers and other devices.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47460</p> <p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on clinical record review, facility documentation review, facility policy review, and agency staff file review for three of three agency NAs (NA #1, 2 and 3), the facility failed to ensure agency staff received facility orientation to include emergency procedures and abuse training prior to working in the facility. The findings include:</p> <p>A. Agency NA #1 file review identified NA #1 worked at the facility on 12/28/2024 during the 3 to 11 PM shift. File review for NA #1 failed to identify a general orientation to include facility emergency procedures and abuse training.</p> <p>B. Agency NA #2 file review identified NA #2 worked at the facility on 9/2/2023 during the 3 to 11 PM shift. File review for NA #2 failed to identify a general orientation to include facility emergency procedures and abuse training.</p> <p>C. Agency NA #3 file review identified NA #3 worked at the facility on 9/2/2023 during the 3 to 11 PM shift. File review for NA #3 failed to identify a general orientation to include facility emergency procedures and abuse training.</p> <p>Interview, facility documentation review and facility policy review with the Administrator on 1/16/2025 at 1:08 PM identified the medical records/scheduler orients agency/pool staff. The medical records/scheduler provides agency staff with a tour of the facility and includes emergency procedures and abuse training for agency staff, which was located in a facility binder. The Administrator stated the facility did not have documentation that education, including facility emergency procedures and abuse training were provided for Agency NA #1, 2 and 3 and was unable to explain why.</p> <p>Review of facility Orientation Policy directed in part, to develop, implement, and maintain an effective orientation process for all new staff, individuals providing services under a contractual agreement, consistent with their expected roles. Orientation consists of in-depth review of resident population, policies and procedures (including emergency procedures, care procedures). General orientation must be completed prior to the employee's formal contact with facility residents.</p>		