

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  02/04/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of two sampled residents (Resident #35) reviewed for hospitalization, the facility failed to ensure medication was administered as ordered. The findings include:</p> <p>Resident #35's diagnoses included epilepsy, dementia and anxiety.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #35 was moderately cognitively impaired, had no behaviors, required max assistance for bed mobility, dressing, and hygiene, was dependent for transfers, utilized a mechanical lift and utilized a wheelchair for mobility.</p> <p>The physician's orders for June/July 2024 (original order dated 10/5/22) directed to administer Clobazam (benzodiazepine/used to treat seizures) 10mg orally once a day in the evening.</p> <p>The Controlled Substance Disposition Record dated 6/14/24 indicated a 30-day supply (30 tabs) of Clobazam 10mg tablets were delivered to the facility on 6/14/24. The disposition record identified that the last dose administered was on 7/13/24.</p> <p>Review of the medication administration record (MAR) for the month of July/2024 identified the Clobazam was not administered on 7/14, 7/15, &amp; 7/16/24.</p> <p>The nurse's note, dated 7/16/24 at 10:31 PM written by RN #3 identified Resident #35 was not feeling well, had difficulty pronouncing words, and had labored breathing with an expiratory wheeze. The advanced practice registered nurse (APRN) and family were notified and the family wanted Resident #35 to be sent out to the hospital to be evaluated</p> <p>A medication error report dated 7/17/24 indicated that Clobazam 10mg was not administered as ordered on 7/14/24 resulting in Resident #52 being hospitalized for 24 hours. The report further indicated that the evaluation at the hospital was negative.</p> <p>The nurses note dated 7/17/24 at 4:13 AM written LPN #1 indicated a call was received from the hospital physician inquiring about the last administration of Clobazam. Per the MAR, it was last administered on 7/13/24. There were missed doses on 7/14-7/16/24 as the medication was not available.</p> <p>A Reportable Event report dated 7/17/24 indicated Resident #35 missed 3 doses of Clobazam medication due to the medication not being available and Resident #35 was sent to the hospital to be evaluated for shortness of breath.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The blood serum laboratory results for Resident #35 dated 7/17/24 indicated Clobazam was at a level of 202 with the normal range noted as 30-300 nanograms per milliliter (ng/ml).</p> <p>Interview on 1/30/25 at 12:15 PM with the DNS identified that the pharmacy requested a prescription to refill the Clobazam and APRN #1 wrote the prescription electronically. The medication was still not refilled by the pharmacy so LPN #3 cancelled the original order for the Clobazam, hoping a new order would expedite getting the medication but it did not. The pharmacy was contacted and indicated the medication had been discontinued, which was not the case. A new order was sent to the pharmacy. DNS further identified that when a medication is not received from the pharmacy within 24-48 hours, a call needs to be placed to the pharmacy.</p> <p>Interview on 1/30/25 at 12:32 PM with RN #2 (day supervisor) indicated the medication refills and orders are completed through the electronic medical record (EMR) system. There is a button in the EMR for refilling medications and it shows the date of the last request/refill. All staff are responsible for reordering medications. Medications are re-ordered when a 5-day supply is remaining. When a controlled medication is ordered, a prescription is required, unless it is a previous order with refills on it. If there were refills on it, then a prescription is not required. The APRN and or MD can call the pharmacy to order or refill a controlled medication and can fax or order electronically through the EMR. Any new controlled medications require a prescription. RN #2 was unable to recall any issue with Resident #35's seizure medication in July of 2024.</p> <p>Interview on 1/30/25 at 12:45 PM with the Pharmacist associated with the pharmacy identified that a 30-day supply of Clobazam was filled on 6/13/24 with an additional 3 refills remaining. He noted that the medication was refilled on 7/17/25. The Pharmacist could not identify any issues related to the refilling of the Clobazam in July 2024 because a new prescription was not needed in order for the medication to be refilled. The Pharmacist further noted that there were no notes related to the refilling of the medication from July 2024. He further noted that he found no billing issues that would have affected the medication being refilled and he noted that not receiving three doses of an antiseizure medication, may increase the risk of having seizures.</p> <p>Interview on 1/31/25 at 9:17 AM with Person #1 identified Resident #35 was evaluated for a stroke at the hospital and noted that while the resident was at the hospital, the emergency room physician notified him/her that Resident # 35 had not received 3 doses of the Clobazam. Person #1 identified that the facility did not notify him/her that the medication had not been administered for three days.</p> <p>Interview on 2/3/25 at 2:31 PM with APRN #1 identified the DNS notified her that Resident #35 had missed doses of Clobazam. She further noted that Resident #35 was at a higher risk for having a seizure with the missed doses. APRN #1 identified that she had contacted the resident's Neurologist (MD #1) and after he viewed a video (the resident had a camera with a video feed installed in his/her room) of the incident with the Resident, he noted non-rhythmic shaking of the right hand only and identified that he suspected that changes in the resident and the shaking of the right hand were not related to the resident experiencing a seizure because Resident #35 had a structural abnormality on the right frontotemporal and parietal lobes of the brain.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 2/4/25 at 11:44 AM with LPN #2 indicated the clobazam was not available from the pharmacy. There were refills remaining, yet the pharmacy showed no refills available. That incident was a pharmacy error. That's why the medication was not delivered. The EMR showed refills remaining. When the pharmacy was contacted, they did not show or see any refills remaining. The pharmacy had incorrect data regarding the refills. The pharmacy was contacted multiple times to refill the Clobazam. LPN #2 was re-educated on contacting the pharmacy, APRN and DNS, if or when a medication is unavailable in order to escalate a solution.</p> <p>Review of the Medication Administration policy directed, in part, that medications were administered by licensed nurses, as ordered by the physician and in accordance with professional standards of practice. To report and document any adverse side effects or refusals, and to correct any discrepancies and report to the nurse manager.</p>		