STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075374	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monsignor Bojnowski Manor	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies and interviews for one (1) of one (1) sampled resident (Resident #1) reviewed for an allegation of involuntary seclusion, the facility failed to report a change in behavior to the physician when facility staff were unable to de-escalate Resident #1's increased agitated behaviors which resulted in facility staff placing Resident #1 in the medication room with the door closed for one and one half (1 1/2) hours. The findings include: Resident #1's diagnoses included dementia, insomnia, end stage renal disease, failure to thrive, and depression.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 9), unable to make reasonable and consistent decisions regarding tasks of daily living, was dependent with all care including bed mobility and transfers, and was wheelchair bound. The Resident Care Plan (RCP) dated 12/23/25 identified Resident #1 had a self-care deficit. Interventions directed staff to assess the resident every shift and if Resident #1's mood was declining to order psychiatric services.Review of the nurse's notes from 2/9/26 to 2/21/26 identified Resident #1 often yelled out continuously throughout the shift. Resident #1 would decrease yelling when brought into the hallway near the nurse's station. The Family Nurse Practitioner (FNP) note dated 2/12/26 identified Resident #1 was seen after having two (2) falls over four (4) days with increased confusion with a dementia diagnosis and anxiety. The FNP discussed with family members starting low-dose Trazodone in the evening for increased anxiety and restlessness, but the family member declined at the time.The Nurse's note dated 2/26/26 at 11:53 AM, documented as an addendum note for 2/24/26, by the Director of Nursing (DON) identified on 2/21/26 on the 3:00 PM to 11:00 PM shift, Resident #1 was placed behind the nurse's station in the medication room for close observation. Resident #1's family member, law enforcement, and the Advanced Practice Registered Nurse (APRN) were notified.Review of the nurse's notes and clinical record from 2/20/26 to 2/21/26 failed to identify the physician was notified of Resident #1 exhibiting an increase in agitated behaviors in the twenty-four hours leading up to the 2/21/26 incident.A written statement by NA #1 dated 2/26/26 identified she brought Resident #1 to the nurse's station because Resident #1 was anxious and trying to get out of bed. RN #2 (the 7:00 PM to 7:00 AM Nursing Supervisor) placed Resident #1 in the medication room. NA #1 was surprised because she never saw this done in the eight (8) years she worked at the facility and identified RN #2 said she did this because it was easy to watch Resident #1. A written statement by LPN #1 (the 11:00 PM to 7:00 AM Charge Nurse) dated 2/26/26 identified when she arrived for work on 2/21/26 at about 11:00 PM she saw Resident #1 lying in his/her wheelchair in the medication room with the door shut. She asked RN #1 why Resident #1 was in solitary confinement. RN #1 responded, He/she won't stop screaming and he/she has been yelling all evening. LPN #1 then asked RN #2 the same question and RN #2 responded, I am the supervisor and decided to bring him/her out here so other residents could get some sleep. LPN #1 then went into the medication room to check on Resident #1. The medication room door was unlocked. Sometime after 12:10 AM, LPN #1 asked the NA to check a full set of vital signs on Resident #1 which were normal. The NA then brought Resident #1 back to his/her room and (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 slept for the remainder of the night.Review of the facility Summary Report dated 3/2/26 at 12:00 AM by the Director of Nursing (DON), identified facility staff members were interviewed and it was noted on 2/21/26, Resident #1 exhibited increased agitation and restlessness beyond Resident #1's baseline. At the end of the 3:00 PM to 11:00 PM shift NA # 1 brought Resident #1 to the nurse's station area due to Resident #1's restlessness and high fall risk. RN #2 determined that, due to Resident #1's increased agitation, restlessness, and high fall risk, it would be safest to maintain Resident #1 under direct observation. When attempting to position Resident #1 behind the nursing station, it was determined that his/her custom wheelchair wound not fit in the space. RN #2 placed Resident #1 in the medication room located directly behind the nursing station.Interview with RN #1 on 3/2/26 at 12:55 PM identified on 2/21/26 she worked from 3:00 PM to 11:00 PM. Resident #1 was screaming throughout the entire shift. RN #1 could typically redirect the resident but was unable to on 2/21/26. NA #1 was getting ready to end her shift and RN #2 directed NA #1 to bring Resident #1 to the nurse's station. RN #2 attempted to bring Resident #1 close to her behind the nurse's station but was unable to fit the resident with his/her wheelchair so she placed Resident #1 in the medication room with the door shut. Interview with RN #2 on 3/2/26 at 1:15 PM identified she placed Resident #1 in the medication room with the door shut because the resident was screaming and was trying to climb out of bed. She called the family member around 4:30 AM but had not called the family member prior to that to see if the family member could help de-escalate the situation. Interview with the DON on 3/2/26 at 1:35 PM identified she first heard about Resident #1 being placed in the medication room when randomly speaking to staff about interactions with RN #2. At that time, LPN #1 identified witnessing Resident #1 being placed in the medication room on 2/21/26. The DON identified staff should not have placed Resident #1 in the medication room and should have made a better decision or called her for guidance. After completion of their investigation the facility identified they would no longer utilize RN #2, who was an agency nurse, to fill vacant shifts. Although attempted, a call was not returned by NA#1 and LPN #1.Review of the facility policy for Dementia Care, directed in part that appropriate referrals (physician/mental health provider) would be made if current interventions were ineffective or the resident showed a decline in psychosocial, mood or behavioral status.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies and interviews for one (1) of one (1) sampled resident (Resident #1) reviewed for an allegation of involuntary seclusion, the facility failed to ensure Resident #1 was not separated from other residents or his/her room when they placed the resident in the medication room with the door closed for one and one half (1 1/2) hours when Resident #1 exhibited increased agitated behaviors. The findings include:Resident #1's diagnoses included dementia, insomnia, end stage renal disease, failure to thrive, and depression.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 9), unable to make reasonable and consistent decisions regarding tasks of daily living, was dependent with all care including bed mobility and transfers, and was wheelchair bound.The Resident Care Plan (RCP) dated 12/23/25 identified Resident #1 had a self-care deficit. Interventions directed staff to assess the resident every shift, administer medications as ordered, encourage the resident to participate in care, and if Resident #1's mood was declining or the resident was self-isolating, to order psychiatric services and encourage the resident to express his/her feelings.Review of the nurse's notes from 2/9/26 to 2/21/26 identified Resident #1 often yelled out continuously throughout the shift. Resident #1 would decrease yelling when brought into the hallway near the nurse's station.The Family Nurse Practitioner (FNP) note dated 2/12/26 identified Resident #1 was seen after having two (2) falls over four (4) days with increased confusion with a dementia diagnosis, anxiety and further decline of oral intake. Resident #1 was in consultation with palliative care at the VA; however, the family was continuing all treatment at the facility. The FNP discussed with family members starting low-dose Trazodone in the evening for increased anxiety and restlessness, but the family member declined at the time.Review of the facility Reportable Event Form dated 2/25/26, identified a staff member reported that on 2/21/26 at 10:58 PM, Resident #1 was seen in the medication room with the door shut. The facility initiated an investigation and made proper notifications at that time.The Nurse's note dated 2/26/26 at 11:53 AM, documented as an addendum note for 2/24/26, by the Director of Nursing (DON) identified on 2/21/26 on the 3:00 PM to 11:00 PM shift, Resident #1 was placed behind the nurse's station in the medication room for close observation. Resident #1's family member, law enforcement, and the Advanced Practice Registered Nurse (APRN) were notified.A written statement by NA #1 dated 2/26/26 identified she brought Resident #1 to the nurse's station because Resident #1 was anxious and trying to get out of bed. RN #2 (the 7:00 PM to 7:00 AM Nursing Supervisor) placed Resident #1 in the medication room. NA #1 was surprised because she never saw this done in the eight (8) years she worked at the facility and identified RN #2 said she did this because it was easy to watch Resident #1.A written statement by LPN #1 (the 11:00 PM to 7:00 AM Charge Nurse) dated 2/26/26 identified when she arrived for work on 2/21/26 at about 11:00 PM she saw Resident #1 lying in his/her wheelchair in the medication room with the door shut. She asked RN #1 why Resident #1 was in solitary confinement. RN #1 responded, He/she won't stop screaming and he/she has been yelling all evening. LPN #1 then asked RN #2 the same question and RN #2 responded, I am the supervisor and decided to bring him/her out here so other residents could get some sleep. LPN #1 then went into the medication room to check on Resident #1. The medication room door was unlocked. Sometime after 12:10 AM, LPN #1 asked the NA to check a full set of vital signs on Resident #1 which were normal. The NA then brought Resident #1 back to his/her room and Resident #1 slept for the remainder of the night.Interview with RN #1 on 3/2/26 at 12:55 PM identified on 2/21/26 she worked from 3:00 PM to 11:00 PM. Resident #1 was screaming throughout the entire shift. RN #1 could typically redirect the resident but was unable to on 2/21/26. NA #1 was getting ready to end her shift and RN #2 directed NA #1 to bring Resident #1 to the nurse's station. RN #2 attempted to bring Resident #1 close to her (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behind the nurse's station but was unable to fit the resident with his/her wheelchair so she placed Resident #1 in the medication room with the door shut. The medication room had clear glass panels and Resident #1 was visually seen while in the room.Interview with RN #2 on 3/2/26 at 1:15 PM identified she placed Resident #1 in the medication room with the door shut because the resident was screaming and was trying to climb out of bed. She called the family member around 4:30 AM but had not called the family member prior to that to see if the family member could help de-escalate the situation.Interview with the DON on 3/2/26 at 1:35 PM identified she first heard about Resident #1 being placed in the medication room when randomly speaking to staff about interactions with RN #2. At that time, LPN #1 identified witnessing Resident #1 being placed in the medication room on 2/21/26. The DON identified staff should not have placed Resident #1 in the medication room and should have made a better decision or called her for guidance. After completion of their investigation the facility identified they would no longer utilize RN #2, who was an agency nurse, to fill vacant shifts.Although attempted, a call was not returned by NA#1 and LPN #1.Review of the facility policy for Abuse, directed in part that it was the facility's policy to protect the health, welfare, and rights of each resident. The facility would protect residents from involuntary seclusion which referred to the separation of a resident from other residents or his/her room against the residents' will or the will of the residents' representatives.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies and interviews for one (1) of one (1) sampled resident (Resident #1) reviewed for an allegation of involuntary seclusion, the facility failed to timely report the allegation of involuntary seclusion. The findings include:Resident #1's diagnoses included dementia, insomnia, end stage renal disease, failure to thrive, and depression.The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was moderately cognitively impaired (Brief Interview for Mental Status (BIMS) score of 9), unable to make reasonable and consistent decisions regarding tasks of daily living, was dependent with all care including bed mobility and transfers, and was wheelchair bound.The Resident Care Plan (RCP) dated 12/23/25 identified Resident #1 had a self-care deficit. Interventions directed staff to assess the resident every shift, administer medications as ordered, encourage the resident to participate in care, and if Resident #1's mood was declining or the resident was self-isolating, to order psychiatric services and encourage the resident to express his/her feelings. Review of the facility Reportable Event Form dated 2/25/26, identified a staff member reported that on 2/21/26 at 10:58 PM, Resident #1 was seen in the medication room with the door shut. The facility initiated an investigation and made proper notifications at that time.The Nurse's note dated 2/26/26 at 11:53 AM, documented as an addendum note for 2/24/26, by the Director of Nursing (DON) identified Resident #1 was placed behind the nurse's station in the medication room for close observation. A written statement by NA #1 dated 2/26/26 identified she brought Resident #1 to the nurse's station because Resident #1 was anxious and trying to get out of bed. RN #2 (the 7:00 PM to 7:00 AM Nursing Supervisor) placed Resident #1 in the medication room. NA #1 was surprised because she never saw this done in the eight (8) years she worked at the facility and identified RN #2 said she did this because it was easier to watch Resident #1. NA #1 further identified she did not report the incident as abuse because she did not know RN #2 had done something wrong.A written statement by LPN #1 (the 11:00 PM to 7:00 AM Charge Nurse) dated 2/26/26 identified when she arrived for work on 2/21/26 at about 11:00 PM she saw Resident #1 lying in his/her wheelchair in the medication room with the door shut. She asked RN #1 why Resident #1 was in solitary confinement. RN #1 responded, He/she won't stop screaming and he/she has been yelling all evening. LPN #1 then asked RN #2 the same question and RN #2 responded, I am the supervisor and decided to bring him/her out here so other residents could get some sleep. LPN #1 then went into the medication room to check on Resident #1. The medication room door was unlocked. Sometime after 12:10 AM, LPN #1 asked the NA to check a full set of vital signs on Resident #1 which were normal. The NA then brought Resident #1 back to his/her room and Resident #1 slept for the remainder of the night. Interview with LPN #2 (the 3:00 PM to 11:00 PM charge nurse) on 3/2/26 at 12:35 PM identified she was not working on Resident #1's unit on 2/21/26 but saw staff placed Resident #1 in the medication room. LPN #2 questioned RN #2 about Resident #1 being in the medication room because she had never seen a staff member do that, but she did not receive an answer from RN #2. LPN #2 identified the medication room door was shut. LPN #2 further identified she had been trained in Abuse and Neglect and was aware Involuntary Seclusion was a form of abuse. LPN #2 identified she did not report the incident because Resident #1 was not her patient.Interview with RN #1 on 3/2/26 at 12:55 PM identified on 2/21/26 she worked from 3:00 PM to 11:00 PM. Resident #1 was screaming throughout the entire shift. RN #2 directed NA #1 to bring Resident #1 to the nurse's station. RN #2 placed Resident #1 in the medication room with the door shut. RN #1 did not report this as suspected abuse because she felt they were preventing the resident from falling and from waking up other residents.Interview with RN #2 on 3/2/26 at 1:15 PM identified she placed Resident #1 in the medication room with the door shut because the resident was screaming and was trying to climb out of bed. She did not feel this was abuse because she was watching Resident #2 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while he/she was in the medication room.Interview with the DON on 3/2/26 at 1:35 PM identified she first heard about Resident #1 being placed in the medication room when randomly speaking to staff about interactions with RN #2. At that time, LPN #1 identified witnessing Resident #1 being placed in the medication room on 2/21/26. The DON identified staff should not have placed Resident #1 in the medication room and should have made a better decision or called her for guidance. After completion of their investigation the facility identified they would no longer utilize RN #2, who was an agency nurse, to fill in vacant shifts.Although attempted, a call was not returned by NA #1 and LPN #1.Review of the facility policy for Abuse, directed in part that any suspected abuse was to be reported to the Administrator immediately, but no longer than two (2) hours after an allegation of abuse is made.