

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/30/2026
NAME OF PROVIDER OR SUPPLIER Monsignor Bojnowski Manor, Inc		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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure supervision to prevent a resident from leaving the facility without staff knowledge. The findings include: Resident #1's diagnoses included dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 was severely cognitively impaired, had wandering behavior noted one (1) to three (3) of the prior seven (7) days that placed Resident #1 at significant risk of getting to a potentially dangerous place, and required supervision/touching assistance with transfers and ambulation with a walker. A physician order dated 6/28/2026 directed wander guard to the left ankle due to wandering, with check every shift for monitoring, and check function every night shift. Review of Physical Therapy Progress note dated 7/10/2026 identified Resident #1 transferred and ambulated with supervision or touching assistance. A facility Reportable Event (RE) Form identified on 7/12/2026 at 8:22 AM identified Resident #1 ambulated with one assist and a rolling walker, and at 3:52 AM Resident #1 was noted standing outside the door to the XXXXXX solarium at 3:52 AM. Resident #1 was redirected back inside the building. Additional RE information dated 7/13/2026 identified Resident #1 was previously identified as a wander/elopement risk and had a wander guard bracelet on the left ankle. Resident #1 was last observed about 3 AM in the hallway. Resident #1 exited from the dining room/recreation room, had walked approximately 300 feet from the door, was wearing night clothing: and non-skid slippers, and had no injuries noted. The RE Summary report dated 7/15/2026 identified on 7/12/2026 an alarm went off and staff identified the alarm was for dining room door and Resident #1 had exited building. A Dr. Hunt (search for a missing resident) was initiated and staff noted Resident #1 standing outside the XXXXXX solarium door. Resident #1 was returned to the building with no injuries identified and was placed on one-to-one (1:1) observation. Weather on-line search for Sunday, 7/12/2026 identified the weather between 2 AM and 4 AM was in the low 60's with zero precipitation. Record review identified nursing note dated 7/12/2026 at 8:49 AM by RN #1 (supervisor) identified Resident #1 was confused and wandered outside through a facility door. APRN note effective 7/12/2026 at 2 PM identified Resident #1 was seen for follow up and report of elopement. Resident #1 stated he/she did not know he/she could not go outside and thought a family member was waiting for him/her. Resident #1 was always confused, a PRN (as needed) Trazodone was given last night with no effect, previously with positive effect. Plan: schedule Trazodone 25 milligrams twice daily for anxiety and restlessness, and continue as needed Trazodone order, message left for responsible party. Review of RN #1 (supervisor) written statement dated 7/12/2026 identified at approximately 3:15 AM she was notified the exit door alarms were sounding. The statement indicated RN #1 was aware Resident #1 had been wandering during the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift and staff began searching. Resident #1 was located by LPN #1 and no injuries were identified. NA #2 written statement dated 7/13/2026 identified prior to providing other residents with care, she and NA #1 had asked LPN #1 to keep a close eye on Resident #1 who was wandering. Subsequently she noted the exit door alarms sounding. She notified LPN #1 of the alarm and that someone may have exited through one of the secured doors and stayed with another wandering resident while the search began. Although attempted, an interview with RN #1 and NA #2 were unable to be obtained during the survey. Interview and record review with NA #1 on 7/30/2026 at 10:53 AM identified on 7/12/2026 during the 11 PM to 7 AM shift, Resident #1 was not her resident, but she was familiar with him/her. Resident #1 had indicated he/she was looking for his/her spouse and NA #1 kept a close eye on the resident and frequently redirected him/her throughout the shift. NA #1 last saw Resident #1 at 3 AM. NA #1 indicated she and NA #2 were providing other residents with care and had asked LPN #1 to keep an eye on Resident #1 due to his/her wandering. Interview and record review on 7/30/2026 at 11:08 AM with LPN #1 identified he was the charge nurse on 7/12/2026 when Resident #1 was found outside. About 3 AM he was administered a resident medications when NA #1 and NA #2 asked him to keep an eye on Resident #1 who was wandering. LPN #1 stated he thought Resident #1 was in bed when he heard the alarms ringing about 10 minutes later. He and RN #1 began searching for Resident #1 and he saw Resident #1 standing outside looking through the glass doorway. He opened the door and let Resident #1 inside. Resident #1 does was not able to say what he/she was doing, and RN #1 assessed Resident #1 with no injury identified. RN #1 indicated Resident #1 apparently had gone out the dining room door. Interview and record review with the Administrator on 7/30/2026 at 11:55 AM with the Administrator identified he had watched a video recording of the 7/12/2026 incident. The Administrator indicated the video coverage did not cover the doorway or all the way down the (length of the) hall. The Administrator stated he viewed NA #2 looking at the alarm panel, with an alarm going off, and saw NA #2 turn it off and NA #2 did not leave area. The alarm went off again, and he then saw LPN #1 and RN #1 check the panel. The video showed a nurse go down the hall towards the dining room an appeared to initiate a Dr. Hunt (search for a missing resident) and staff began searching the building. On video footage LPN #1 was then seen bringing Resident #1 down the hall towards the nursing station. LPN #1 and RN #1 then brought Resident #1 to his/her room. Although requested, facility video surveillance of the hallways was no longer available. Interview and observation with Director of Maintenance and Administrator on 7/30/2026 at 12:18 PM identified the alarm indicated Resident #1 exited through the dining room door near a fenced area that surrounds most of the building. Interview and record review with the DNS on 7/30/2026 at 1:58 PM identified on 7/12/2026 identified Resident #1 was last seen by NA #1 at 3 AM, walking down the hallway towards the dining room. The DNS stated the investigation indicated Resident #1 crossed the dining room, opened the outside door, and went outdoors. DNS indicated video footage identified staff responded to the alarm and located Resident #1 outside, and since the incident Resident #1 will remain on one-to-one (1:1) monitoring. The DNS stated it was all staff's responsibility to monitor residents. Review of facility Elopements and Wandering Residents Policy directed in part; the facility ensures that residents that exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care. Adequate supervision will be provided to prevent accidents or elopements.		