STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075057	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Rehab and Nursing	35 Marc Drive Wallingford, CT 06492

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who required staff assistance with transferring from one (1) surface to another, the facility failed to ensure a gait belt and rolling walker were utilized at the time the resident was transferred. The findings include: Resident #1's diagnoses included osteoarthritis, history of healed traumatic fracture of the right arm, and vascular dementia. The Resident Care Plan dated 6/26/24 identified a self-care deficit, limited physical mobility, and fall risk related to cognitive deficits and deconditioning. Interventions directed to provide active and passive range of motion with care, physical and occupational therapy as needed, call light within reach, quarter length bilateral bed rails for a positioning enabler, assistance of one (1) staff for bathing, dressing, and bed mobility, and assistance of two (2) staff for transfers. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, was dependent on staff for dressing and showers, required maximum assistance for bed mobility and transfers, and was non ambulatory. The nurse's note dated 9/2/24 at 10:32 AM identified Resident #1 complained of pain, bruising to the right upper arm was noted, no trauma was reported, and the Advanced Practice Registered Nurse (APRN) was contacted and directed an x-ray be done. The radiology report dated 9/2/24 at 4:07 PM identified an old, impacted fracture of the right humeral head and neck with healing and there was evidence of osteopenia and osteoporosis. The physician's note dated 9/3/24 at 11:08 AM identified Resident #1 had limited range of motion to the right upper arm and shoulder, complained of pain and tenderness, denied trauma and the physician directed Resident #1 be sent to the Emergency Department for further evaluation and treatment. (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

Printed: 07/31/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/26/2024
NAME OF PROVIDER OR SUPPLIER Skyview Rehab and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 35 Marc Drive Wallingford, CT 06492	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's note dated 9/5/24 at 10:01 AM identified Resident #1 was seen at the hospital and diagnosed with a positive right humerus fracture, Resident #1 was to wear a sling, be non-weight bearing on the right upper extremity, utilize a Hoyer lift for transfers, Tramadol was prescribed for pain, an occupational therapy evaluation was ordered, and follow up with the orthopedic physician. The physician's note indicated the cause of the fracture was unknown and may have been a pathologic fracture due to the osteoporosis. In an interview with the 3-11PM nurse aide, Nurse Aide (NA) #1, on 9/26/24 at 1:25 PM she identified she had worked the 3-11PM shift on 9/1/24 and when providing evening care to Resident #1 she did not notice any bruises. NA #1 explained when she transferred Resident #1 with another staff member, she did not utilize a gait belt. NA #1 identified she and another nurse aide assisted Resident #1 by placing one (1) of their arms under the resident's arm and grabbing his/her pants with their other hand. NA #1 indicated she only used a gait belt if one was available. NA #1 identified the Nursing Supervisor reviewed the policy with her and she is now aware of the proper transfer technique. In an interview the Director of Rehabilitation, Physical Therapist (PT) #1, on 9/26/24 at 2:00 PM, PT #1 identified the proper transfer technique for a resident that requires the assistance of two (2) staff to transfer them, is for one (1) person to stand on each side of the resident and take hold of the gate belt while assisting in the transfer. PT #1 identified staff are not to assist the resident by placing their arm under the resident's arm and it is facility policy to utilize a gait belt whenever physically assisting a resident with transfer or ambulation. Review of the Gait Belt policy directed a gait belt is to be used when a resident requires assistance to transfer or to ambulate. The belt is used to ensure the safety of staff and the resident by providing a secure handhold. The policy further directed that during transfer the staff member is to hold the belt firmly at the resident's sides or the center of the back.