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	01/30/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, clinical record review, interviews, and facility policy for one (1) of three (3) residents (Resident #1) reviewed for medication administration, the facility failed to ensure medications were administered in accordance with safe medication administration practices including resident identification, disposal of refused medications, and limiting medication administration to licensed personnel. The findings included: A nurse's note on 1/3/25 at 10:25 PM by RN #1 identified the unit nurse reported a medication error. Resident #1 received his/her scheduled medications at approximately 8:30 PM, then received another resident's medications at 10:15 PM. 911 was immediately called for transport to the emergency department (ED). Resident #1 was alert, slightly lethargic, and responded verbally and appropriately. The physician, Administrator, Director of Nursing Services (DNS), and emergency contact were updated. An observation on 1/29/26 at 8:58 AM identified LPN #2 administered medications to Resident #3, however, failed to identify Resident #3 prior to administering the medications.Interview with LPN #2 on 1/29/26 at 9:05 AM identified he/she did not check the wrist band to verify the resident during the medication pass because he/she was familiar with the resident. LPN #2 further identified facility policy was to check the resident's wrist band to identify the correct medications were being administered to the correct resident.An observation on 1/29/26 at 9:13 AM identified RN #2 administered medications to Resident #4, however, RN #2 failed to identify Resident #4 prior to administering the medications. Interview with RN #2 on 1/29/26 at 9:13 AM identified he/she forgot to identify Resident #4 prior to administering the medications, that facility policy was to check the resident's wrist band to identify the correct medications were being administered to the correct resident. RN #2 further identified he/she did not confirm the resident's identity because he/she was familiar with the resident.Interview with NA #1 on 1/29/26 at 11:03 AM identified on 1/3/26 LPN #1 requested he/she administer medications to Resident #1. NA #1 proceeded to go into Resident #1's room and administered the medications. NA #1 identified Resident #1's roommate (Resident #2) requested pain medication. NA #1 informed LPN #1 of the request from Resident #2, and it was then identified that the medications NA #1 administered to Resident #1 should have been administered to Resident #2. Interview with LPN #1 on 1/29/26 at 11:17 AM identified Resident #2 refused his/her medications around 8:30 PM on 1/3/26 and requested they be administered later. LPN #1 indicated he/she labeled the medication cup with Resident #2's name and placed the cup back into the medication cart. At 9:00 PM, LPN #1 identified he/she gave the medication cup to NA #1 to administer to Resident #2; however, NA #1 administered the medications to Resident #1 in error. Interview with the DNS on 1/29/26 at 1:48 PM identified the facility's standard of practice was for licensed nurses to prepare and administer medications to residents. The DNS identified medications refused by residents were to be disposed of immediately and should the resident request them to be administered later, new medications should be prepared. The DNS identified nurses were to check the resident's wrist band or identify them by the photo on the electronic medical record prior to (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administering medication(s), even if familiar with resident. The Administration of Medication Policies and Procedures policy directed only licensed personnel were assigned the responsibility for preparing, administering, and recording medications, or are permitted access to drug storage areas at each nurses station, medications should always be prepared and administered by the same licensed person, and medications supplied for one resident shall not be administered to another resident except as defined in a STAT dose procedure. The policy identified resident's name bands or photo identification should be identified before each resident's medications are administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies for one (1) of three (3) residents reviewed for medication administration, the facility failed to ensure a resident was free of a significant medication error when Resident #1 received medications prescribed for another resident. The findings included:1.Resident #1 was admitted to the facility in June of 2021 and had diagnoses that included vascular dementia, Parkinson's disease, and anxiety disorder.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 12), and required maximum assistance with personal hygiene, bathing, and dressing.The Resident Care Plan (RCP) dated 12/3/25 identified Resident #1 used antipsychotic medications for Parkinson's disease related to hallucinations. Interventions directed to administer medication per physician orders, observe for side effects and effectiveness each shift, and to report negative signs and symptoms to the physician.The Medication Administration Report (MAR) dated 1/3/26 identified Resident #1 was administered the following evening medications: 80 milligrams of atorvastatin (for treatment of high cholesterol), 20 units of insulin glargine (for treatment of diabetes), 400 milligrams of Magnesium Glycinate (supplement), 2 milligrams of Prazosin (for treatment of nightmares), 500 milligrams of Divalproex Sodium (for treatment of tremors, major depressive disorder), 100 milligrams of Docusate Sodium (for treatment of constipation), 500 milligrams of Metformin (for treatment of diabetes), 12.5 milligrams of metoprolol (for treatment of hypertension), 17.2 milligrams of Sennosides (for treatment of constipation), 500 milligrams of Vitamin C (supplement), 600 milligrams Gabapentin (for treatment of neuropathy), one and one half tablets of 25-100 milligrams of Sinemet (for treatment of Parkinson's Disease), 1000 milligrams of Tylenol (for treatment of pain), and 50 milligrams of Tramadol (for treatment of severe pain). 2. Resident #2 was admitted to the facility in April 2023 and had diagnoses that included bipolar disorder, Type 2 diabetes mellitus, and atherosclerotic heart disease.The Resident Care Plan (RCP) dated 10/14/25 identified Resident #2 had a mood problem related to major depressive disorder, bipolar disorder, and anxiety disorder. Interventions directed to administer medication per physician orders and to monitor for side effects and effectiveness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a moderately impaired cognition (Brief Mental Interview for Mental Status (BIMS) of 12), and required moderate assistance with personal hygiene, bathing, and dressing.The 1/3/26 Medication Administration Report for Resident #2 identified the following medications were refused: 80 milligrams of atorvastatin (for treatment of high cholesterol), 15 milligrams of Belsomra (for treatment of insomnia) 60 milligrams Lurasidone (for treatment of depression), 200 milligrams Trazodone (for treatment of insomnia), 5 milligrams Buspirone (for treatment of depression), 6.25 milligrams carvedilol (for treatment of hypertension), 100 milligrams doxycycline (for treatment of infection), and 1000 milligrams Metformin (for treatment of diabetes). A nurse's note on 1/3/25 at 10:25 PM by RN #1 identified the unit nurse reported a medication error. Resident #1 received his/her scheduled medications at approximately 8:30 PM, then received another resident's medications at 10:15 PM. 911 was immediately called for transport to the emergency department (ED). Resident #1 was alert, slightly lethargic, and responded verbally and appropriately. The physician, Administrator, Director of Nursing Services (DNS), and emergency contact were updated. The hospital Discharge summary dated [DATE] identified Resident #1 was admitted after receiving medications intended for another resident including trazodone, lurasidone, buspirone, carvedilol, doxycycline, and metformin. The summary identified the resident developed encephalopathy more likely related to trazodone toxicity but could also have been metabolic encephalopathy in the setting of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RSV infection and hypoxia.Interview with NA #1 on 1/29/26 at 11:03 AM identified on 1/3/26 LPN #1 requested he/she administer medications to Resident #1. NA #1 proceeded to go into Resident #1's room and administered the medications. NA #1 identified Resident #1's roommate (Resident #2) requested pain medication. NA #1 informed LPN #1 of the request from Resident #2, and it was then identified that the medications NA #1 administered to Resident #1 should have been administered to Resident #2. NA #1 identified facility policy was for licensed nurses to administer medications to residents; however, it was a busy night, and he/she did not think the request through prior to administering the medications.Interview with LPN #1 on 1/29/26 at 11:17 AM identified Resident #2 refused his/her medications around 8:30 PM on 1/3/26 and requested they be administered later. LPN #1 indicated he/she labeled the medication cup with Resident #2's name and placed the cup back into the medication cart. At 9:00 PM, LPN #1 identified he/she gave the medication cup to NA #1 to administer to Resident #2; however, NA #1 administered the medications to Resident #1 in error. LPN #1 further indicated it was the responsibility of licensed nurses to administer medications to the residents. LPN #1 further indicated it was easier to give NA #1 the medications that evening as NA #1 was heading towards Resident #1's room at the time of the request. Interview with MD #1 on 1/30/26 at 11:59 AM identified the potential effects of Resident #1 receiving medications intended for another resident. MD #1 identified administration of a total of 1500 milligrams of metformin could place the resident at risk for low blood sugar. MD #1 further identified administration of a total of 200 milligrams of tramadol could cause hypotension, drowsiness, lethargy, and nausea/vomiting, which occurred. MD #1 indicated Resident #1 was administered intravenous normal saline and the resident's blood pressure stabilized. MD #1 additionally identified administration of 6.25 milligrams of carvedilol in addition to the 12.5 milligrams of metoprolol previously administered could result in a decrease in blood pressure and heart rate.Interview with the DNS on 1/29/26 at 1:48 PM identified the facility's standard of practice was for licensed nurses to prepare and administer medications to residents. The DNS identified medications refused by residents were to be disposed of immediately and should the resident request them to be administered later, new medications should be prepared and administered to the resident. The Administration of Medication Policies and Procedures policy directed only licensed personnel were assigned the responsibility for preparing, administering, and recording medications, or are permitted access to drug storage areas at each nurses station, medications should always be prepared and administered by the same licensed person, and medications supplied for one resident shall not be administered to another resident except as defined in a STAT dose procedure.