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	04/24/2026

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for elopement risk, the facility failed to ensure a resident, who was alert and oriented and had no previous documented exit seeking behaviors while in the facility, was free from restraint when a Wanderguard device (a bracelet which is a part of a wander management system designed to prevent those at risk for wandering from leaving a protected area) was applied to the resident prior to receiving consent from the conservator, restricting the resident's freedom of movement. Following the placement of the Wanderguard, Resident #1 was granted a Leave of Absence (LOA) with a friend and did not return to the facility as planned. The findings include:Resident #1?s diagnoses included bipolar disorder (a mental health condition characterized by intense and fluctuating mood shifts including extreme highs and lows), dementia without behavioral disturbances and anxiety disorder.The Court of Probate document identified Resident #1 was appointed a conservator of person (Person #1), in part, to ensure personal care, comfort, safety and maintenance, and medical or other professional care effective 2/17/26.The Nursing Evaluation dated 3/16/26 identified Resident #1 was admitted to the facility and was alert and oriented to person, place, time and situation, was verbally appropriate and was independent with all Activities of Daily Living (ADLs), bed mobility, transfers and ambulation.A physician's order dated 3/16/26 directed Resident #1 may go on LOA with someone.An Elopement Risk Scale dated 3/16/26 identified Resident #1 was not at risk for elopement.Review of nurse's notes dated 3/16/26 through 3/18/26 failed to identify disorientation, verbalization of wanting to leave the facility or exit seeking behaviors.A nurse's note by LPN #1 dated 3/19/26 at 2:22 PM identified a Wanderguard was placed on Resident #1's left ankle due to exit seeking and an elopement assessment was completed. The note failed to identify that Person #1 was contacted for approval prior to the placement of the Wanderguard.An Elopement Evaluation dated 3/19/26 identified Resident #1 was at risk for elopement.A physician's order dated 3/19/26 directed a Wanderguard was placed to Resident #1's left ankle and placement was to be checked every shift.Review of the March 2026 Medication Administration Record (MAR) failed to identify Resident #1 exhibited any behaviors from 3/16/26 through 3/19/26.The Resident Care Plan (RCP) dated 3/20/26 identified Resident #1 was an elopement risk related to impaired safety awareness and exit seeking behaviors. Interventions included observing for and reporting verbalizations of wanting to leave the facility and placing a Wanderguard to the resident's left ankle and checking it every shift for placement and function daily on the 11:00 PM to 7:00 PM shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was independent with bed mobility, transfers and ambulation and Resident #1 did not exhibit any behaviors, including wandering behaviors.Review of nurse's notes dated 3/20/26 through 3/28/26 failed to identify disorientation, verbalization of wanting to leave the facility or exit seeking behaviors.A nurse's note by RN #2 dated 3/29/26 at 11:38 AM identified Resident #1 requested to go LOA with a friend but Resident #1 nor herself (RN #2) were able to contact Person #1 despite (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	messages left, so Resident #1 was notified he/she could not go on a LOA and stayed in the facility with the friend.Review of the March 2026 MAR and TAR failed to identify Resident #1 was being monitored for wandering or exit seeking behaviors although a Wanderguard was placed on 3/19/26.A late entry nurse's note by RN #1 dated 3/30/26 at 10:15 AM (created on 3/31/26 at 7:14 AM) identified he called Person #1 to discuss Resident #1 going out on a LOA with a friend and Person #1 consented to Resident #1 going on a LOA.A late entry nurse's note by RN #1 dated 3/30/26 at 12:10 PM (created on 3/31/26 at 7:15 AM) identified Resident #1's friend came to the facility to take Resident #1 on LOA and stated they would return around 6:00 PM and the LOA book was signed.A late entry nurse's note by RN #2 dated 3/31/26 at 12:32 AM (created on 3/31/26 at 10:08 AM) identified at 10:15 PM, Resident #1 had not returned from LOA after leaving at 12:05 PM. Resident #1's friend was contacted and three (3) voicemails were left without return call. Resident #1 was contacted and the voicemail was full. Resident #1's son was contacted and reported not knowing anything about Resident #1. Person #1 was contacted and a voicemail and email were left, the police were notified, the APRN was notified and the DON was notified. It was later identified that most of Resident #1's belongings were gone from the room. The police later followed up and reported being unable to contact the friend that took Resident out on LOA but they would continue their search.A nurse's note by RN #1 dated 4/1/26 at 12:03 PM identified a call was received at 10:00 AM from Resident #1's brother stating Resident #1 called him/her at 9:50 AM reporting he/she (Resident #1) was fine and would call Person #1.Review of the facility census on 4/24/26 identified Resident #1 had not returned to the facility.Interview with Person #1 on 4/24/26 at 10:33 AM identified the facility notified him/her that a Wanderguard was placed on Resident #1 but was unsure of what time and stated they had not reported previous exit seeking or wandering behaviors and did not receive consent prior to the placement of the Wanderguard. Person #1 identified when he/she spoke to RN #1 on 3/30/26 in regards to the LOA, Person #1 reported not being notified of any additional exit seeking behavior and identified he/she knew Resident #1's friend and thought a LOA would be least restrictive, so approved it. Person #1 identified at around 10:00 PM, the facility called and notified him/her Resident #1 never returned, and they could not reach the friend, so they called the police. Person #1 reported he/she had contact with Resident #1 and explained housing options, but Resident #1 stated he/she did not want to return to the facility because it felt like a jail. On 4/3/26, Person #1 reported Resident #1 contacted him/her and wanted to go back to the hospital. The police were called and Resident #1 was transported to the hospital where he/she was admitted and remained on the geriatric psychiatry unit due to the facility refusing to accept Resident #1 back into the facility.Interview with LPN #1 on 4/24/26 at 11:48 AM identified on 3/19/26 Resident #1 was exit seeking and tried to leave the facility. She identified she did not know Resident #1 prior to 3/19/26 and was unaware Resident #1 was conserved. She identified she placed a Wanderguard on Resident #1 without contacting Person #1 for approval and then completed the Elopement Evaluation indicating Resident #1 was at risk for elopement. LPN #1 identified she explained the Wanderguard to Resident #1 and he/she did not resist, and then she notified the nursing supervisor of the behaviors and subsequent placement of the Wanderguard.Interview with the DON on 4/24/26 at 12:05 PM identified on 3/19/26 she was the 7:00 AM to 3:00 PM nursing supervisor and reported she was aware Resident #1 wanted to leave and that LPN #1 placed a Wanderguard on Resident #1. She was unable to recall if she notified Person #1 but identified the communication should have been documented if it occurred. The DON identified she was unsure if it was appropriate to place a Wanderguard on an alert and oriented resident, but Person #1 should have been contacted for approval prior to placement of the Wanderguard. She reported a Wanderguard should not have been placed to Resident #1 following the first episode of exit seeking and that other interventions should have been attempted and documented first. Additionally, she identified once the Wanderguard was placed, wandering/exit seeking behaviors should have been monitored every shift and she was unsure why that had not occurred.Review of the Wanderguard Security System policy dated 7/2023 directed, in part, that a Wanderguard Security Device will be (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed on any resident that the resident care team decides is at risk for wandering away from the facility. When the Wanderguard door alarm sounds, the nearest employees shall immediately respond to that door.Although requested, facility policies on conservator notification and behavior monitoring were not provided.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for facility discharges, the facility failed to permit Resident #1 to return to the facility following a Leave of Absence (LOA) when the resident did not return as planned and subsequently required hospitalization, despite the facility having available beds and lacking documentation to support an Against Medical Advice (AMA) discharge or that readmission would endanger the health or safety of other residents. The findings include: Resident #1?s diagnoses included bipolar disorder (a mental health condition characterized by intense and fluctuating mood shifts including extreme highs and lows), dementia without behavioral disturbances and anxiety disorder.The Court of Probate document identified Resident #1 was appointed a conservator of person (Person #1), in part, to ensure personal care, comfort, safety and maintenance, and medical or other professional care effective 2/17/26.The Nursing Evaluation dated 3/16/26 identified Resident #1 was admitted to the facility and was alert and oriented to person, place, time and situation, was verbally appropriate and was independent with all Activities of Daily Living (ADLs), bed mobility, transfers and ambulation.A physician's order dated 3/16/26 directed Resident #1 may go on LOA with someone. The Resident Care Plan (RCP) dated 3/20/26 identified Resident #1 was an elopement risk related to impaired safety awareness and exit seeking behaviors. Interventions included observing for and reporting verbalizations of wanting to leave the facility and placing a Wanderguard to the resident's left ankle and checking it every shift for placement and function daily on the 11:00 PM to 7:00 PM shift.The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was independent with bed mobility, transfers and ambulation and Resident #1 did not exhibit any behaviors, including wandering behaviors. A late entry nurse's note by RN #1 dated 3/30/26 at 10:15 AM (created on 3/31/26 at 7:14 AM) identified he called Person #1 to discuss Resident #1 going out on a LOA with a friend and Person #1 consented to Resident #1 going on a LOA.A late entry nurse's note by RN #1 dated 3/30/26 at 12:10 PM (created on 3/31/26 at 7:15 AM) identified Resident #1's friend came to the facility to take Resident #1 on LOA and stated they would return around 6:00 PM and the LOA book was signed.A late entry nurse's note by RN #2 dated 3/31/26 at 12:32 AM (created on 3/31/26 at 10:08 AM) identified at 10:15 PM, Resident #1 had not returned from LOA after leaving at 12:05 PM. Resident #1's friend was contacted and three (3) voicemails were left without return call. Resident #1 was contacted and the voicemail was full. Resident #1's son was contacted and reported not knowing anything about Resident #1. Person #1 was contacted and a voicemail and email were left, the police were notified, the APRN was notified and the DON was notified. It was later identified that most of Resident #1's belongings were gone from the room. The police later followed up and reported being unable to contact the friend that took Resident out on LOA but they would continue their search. Review of the facility census identified Resident #1 was discharged from the facility on 3/31/26 Interview with Person #1 on 4/24/26 at 10:33 AM identified the facility would no readmit Resident #1 following the extended LOA, despite Resident #1 returning to the hospital on 4/3/26. The facility communicated Resident #1 required a locked unit which they did not have. Person #1 reported Resident #1 remained on the geriatric psychiatry unit until placement could be found.Interview with the Admissions Director on 4/24/26 at 12:50 PM identified she received hospital referrals for Resident #1 on 4/3/26 and 4/14/26, and although the facility had open female beds on those dates, Resident #1 left against medical advice and refused to return which put the facility at risk for future incidents. She identified Resident #1 was placed on a Corporate denial list from all of their facilities.Interview with the Administrator on 4/24/26 at 1:23 PM identified although Resident #1 returning to the facility would not endanger other residents, Resident #1 was ambulatory without an (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistive device and had the ability to cut off a Wanderguard which puts Resident #1 at risk if he/she were to elope from the facility. She reported she was unaware of the requirements of readmissions for extended LOA's or residents leaving AMA and was unsure if the facility was required to take Resident #1 back.Review of the clinical record failed to identify documentation identifying Resident #1 left AMA or was considered an AMA discharge.Review of the Discharge of Resident policy dated 6/2023 directed, in part, residents will be discharged from the facility as per physician's order. If against medical advice then the resident or responsible party must sign, a release of responsibility form, notify the supervisor immediately and the physician as soon as possible. Record all pertinent documentation in the resident's medical record and describe in detail the sequence of events including specified timed notations.Although requested, facility policies for residents not returning from an LOA and the anticipated time or readmitting discharged residents were unavailable.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for facility discharges, the facility failed to document the resident's discharge in the clinical record and notify the Office of the State Long-Term Care Ombudsman of the resident's discharge. The findings include:Resident #1?s diagnoses included bipolar disorder (a mental health condition characterized by intense and fluctuating mood shifts including extreme highs and lows), dementia without behavioral disturbances and anxiety disorder.The Court of Probate document identified Resident #1 was appointed a conservator of person (Person #1), in part, to ensure personal care, comfort, safety and maintenance, and medical or other professional care effective 2/17/26.The Nursing Evaluation dated 3/16/26 identified Resident #1 was admitted to the facility and was alert and oriented to person, place, time and situation, was verbally appropriate and was independent with all Activities of Daily Living (ADLs), bed mobility, transfers and ambulation.A physician's order dated 3/16/26 directed Resident #1 may go on LOA with someone. The Resident Care Plan (RCP) dated 3/20/26 identified Resident #1 was an elopement risk related to impaired safety awareness and exit seeking behaviors. Interventions included observing for and reporting verbalizations of wanting to leave the facility and placing a Wanderguard to the resident's left ankle and checking it every shift for placement and function daily on the 11:00 PM to 7:00 PM shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was independent with bed mobility, transfers and ambulation and Resident #1 did not exhibit any behaviors, including wandering behaviors. A late entry nurse's note by RN #1 dated 3/30/26 at 10:15 AM (created on 3/31/26 at 7:14 AM) identified he called Person #1 to discuss Resident #1 going out on a LOA with a friend and Person #1 consented to Resident #1 going on a LOA.A late entry nurse's note by RN #1 dated 3/30/26 at 12:10 PM (created on 3/31/26 at 7:15 AM) identified Resident #1's friend came to the facility to take Resident #1 on LOA and stated they would return around 6:00 PM and the LOA book was signed.A late entry nurse's note by RN #2 dated 3/31/26 at 12:32 AM (created on 3/31/26 at 10:08 AM) identified at 10:15 PM, Resident #1 had not returned from LOA after leaving at 12:05 PM. Resident #1's friend was contacted and three (3) voicemails were left without return call. Resident #1 was contacted and the voicemail was full. Resident #1's son was contacted and reported not knowing anything about Resident #1. Person #1 was contacted and a voicemail and email were left, the police were notified, the APRN was notified and the DON was notified. It was later identified that most of Resident #1's belongings were gone from the room. The police later followed up and reported being unable to contact the friend that took Resident out on LOA but they would continue their search. Review of the facility census identified Resident #1 was discharged from the facility on 3/31/26Review of the clinical record failed to identify documentation from the Director of Social Services on the outcome of the LOA or Resident #1 being discharged from the facility.Interview with Person #2 (ombudsman) on 4/24/26 at 1:28 PM identified he/she was not made aware of Resident #1's discharge from the facility or LOA situation. Person #2 reported he/she reviewed the portal and there was no discharge notice submitted for Resident #1. Person #2 identified all discharge notices were required to be sent through the portal to include residents who leave the facility AMA.Interview and review of the Nursing Facility Discharge Notifications on the Long-Term Care Ombudsman portal with the Director of Social Services on 4/24/26 at 1:39 PM, failed to identify Resident #1's 3/31/26 discharge per the facility census was reported via the Long-Term Care Ombudsman portal as required. The Director of Social Services identified although she discharged Resident #1 from the electronic health record, she was unaware that Resident #1 not returning from the LOA was considered a discharge so she did not document on the LOA or the discharge from the facility or send (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification to the Long-Term Care Ombudsman via the portal. She identified she never encountered this scenario before.Interview with the DON on 4/24/26 at 12:05PM identified the Director of Social Services should have documented that Resident #1 was discharged once not returning from the LOA and should have reported Resident #1's discharge on [DATE] via the Long-Term Care Ombudsman portal as required.Review of the Discharge of Resident policy dated 6/2023 directed, in part, to record all pertinent documentation in the resident's medical record and describe in detail the sequence of events including specified timed notations.Although requested a policy on reporting discharges to the Long-Term Care Ombudsman was unavailable.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for elopement risk, the facility failed to ensure the clinical record was complete and accurate to include communication with the resident's conservator prior to a Leave of Absence (LOA) and the anticipated return time of the resident resulting in the preceding nurse being unaware of the resident's anticipated return and delaying notification when the resident did not return from the LOA. The findings include:Resident #1?s diagnoses included bipolar disorder (a mental health condition characterized by intense and fluctuating mood shifts including extreme highs and lows), dementia without behavioral disturbances and anxiety disorder.The Court of Probate document identified Resident #1 was appointed a conservator of person (Person #1), in part, to ensure personal care, comfort, safety and maintenance, and medical or other professional care effective 2/17/26.The Nursing Evaluation dated 3/16/26 identified Resident #1 was admitted to the facility and was alert and oriented to person, place, time and situation, was verbally appropriate and was independent with all Activities of Daily Living (ADLs), bed mobility, transfers and ambulation.A physician's order dated 3/16/26 directed Resident #1 may go on LOA with someone.The Resident Care Plan (RCP) dated 3/20/26 identified Resident #1 was an elopement risk related to impaired safety awareness and exit seeking behaviors. Interventions included observing for and reporting verbalizations of wanting to leave the facility and placing a Wanderguard to the resident's left ankle and checking it every shift for placement and function daily on the 11:00 PM to 7:00 PM shift. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Interview for Mental Status (BIMS) score of 15), was independent with bed mobility, transfers and ambulation and Resident #1 did not exhibit any behaviors, including wandering behaviors.A late entry nurse's note by RN #1 dated 3/30/26 at 10:15 AM (created on 3/31/26 at 7:14 AM) identified he called Person #1 to discuss Resident #1 going out on a LOA with a friend and Person #1 consented to Resident #1 going on a LOA.A late entry nurse's note by RN #1 dated 3/30/26 at 12:10 PM (created on 3/31/26 at 7:15 AM) identified Resident #1's friend came to the facility to take Resident #1 on LOA and stated they would return around 6:00 PM and the LOA book was signed.A late entry nurse's note by RN #2 dated 3/31/26 at 12:32 AM (created on 3/31/26 at 10:08 AM) identified at 10:15 PM, Resident #1 had not returned from LOA after leaving at 12:05 PM. Resident #1's friend was contacted and three (3) voicemails were left without return call. Resident #1 was contacted and the voicemail was full. Resident #1's son was contacted and reported not knowing anything about Resident #1. Person #1 was contacted and a voicemail and email were left, the police were notified, the APRN was notified and the DON was notified. It was later identified that most of Resident #1's belongings were gone from the room. The police later followed up and reported being unable to contact the friend that took Resident out on LOA but they would continue their search.Interview with Person #1 on 4/24/26 at 10:33 AM identified he/she was first notified at 10:00 PM that Resident #1 did not return from the LOA. Person #1 reported she would have liked to have been notified immediately.Interview with RN #1 on 4/24/26 at 11:32 AM identified he spoke with Person #1 for LOA approval on 3/30/26 and confirmed the return time of 6:00 PM on 3/30/26 with Resident #1's friend. RN #1 identified he should have documented the communications in the clinical record prior to the end of his shift. RN #1 was unable to recall if he communicated Resident #1's anticipated return time with RN #2 (3:00 PM to 11:00 PM nursing supervisor) but reported that he should have.Interview with the DON on 4/24/26 at 12:05 PM identified all licensed nurses should complete documentation timely, prior to leaving for their shift. She reported RN #1 was orienting with her on 3/19/26 and identified communication with Person #1 as well as communication with Resident #1. The anticipated LOA return time should have been documented in the clinical record prior to RN #1 (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	leaving for his shift on 3/30/26. Additionally, RN #2 should have been made aware of Resident #1's anticipated return time during shift change. Interview with RN #2 on 4/24/26 at 1:48 PM identified she was not notified by RN #1 or any other staff of the time Resident #1 was expected to return from the LOA on 3/30/26, there was no nurse's note written regarding the LOA, the LOA log did not include an anticipated return time, therefore, she was unaware of when Resident #1 was scheduled to return. She identified many residents return from LOA's as late as 10:00 PM. At 10:00 PM when Resident #1 did not return, she contacted Resident #1's friend, but after calling three (3) times and leaving messages with no return call, she called Resident #1 who's phone went to voicemail. Person #1 and Resident #1's son were unable to locate Resident #1. RN #2 identified if she knew Resident #1 was anticipated to return at 6:00 PM, she would have started making calls to locate Resident #1 after 6:00 PM and would not have waited until 10:00 PM.Review of the LOA Log identified Resident #1 was signed out for the 3/30/26 LOA at 12:05 PM. The log did not identity a column for the anticipated return time, only the time a resident was signed back in.Review of the Leave of Absence (LOA) policy dated 4/2016 directed, in part, the resident must be signed out by the responsible party when leaving and sign in upon return in the LOA log book. Staff will inquire if there is an anticipated duration for the LOA.Review of the Charting and Documentation policy dated 6/2023 directed, in part, services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, functional or psychological condition shall be documented in the resident's medical record an indicated. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.