

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2025
NAME OF PROVIDER OR SUPPLIER  Sky View Rehabilitation & Health Care Center L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 1280 Albany Post Rd Croton on Hudson, NY 10520	
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 - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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 - Actual harm  Residents Affected - Few	<p>Based on record reviews and interviews conducted during an abbreviated survey (NY00382163/ 656232), the facility failed to ensure that each resident received adequate supervision/assistance to prevent accidents for one (1) of three (3) residents reviewed for accidents. Specifically, Resident #1 who required two (2) person assistance for bed mobility was provided one (1) staff assist by Certified Nurse Aide #10 which resulted in a fall from bed. Resident #1 sustained a fractured vertebra and head laceration. This resulted in actual harm for Resident #1 that was not Immediate Jeopardy. The Findings Include: The 07/2017 policy titled 'Activities of Daily Living Care Plan' documented appropriate care and services will be provided for residents who are unable to carry out Activities of Daily Living independently, in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting). Resident #1 was admitted with diagnoses including but not limited to dementia with cerebral infarction (stroke), Alzheimer's Disease, and had a history of ventriculoperitoneal shunt (a device to drain excess fluid from the brain to the abdomen). The quarterly Minimum Data Set (a resident assessment tool) dated 05/17/2025 documented the resident had moderate cognitive impairment and was dependent on staff for assistance with rolling from back to left and right. The resident was always incontinent of bowel and bladder. A Care Plan for Activities of Daily Living dated 02/13/2025 documented the resident required two (2) person assistance with bed mobility and transfer. The Certified Nurse Aide Care Guide (care instructions) dated 10/05/2023, documented the resident was totally dependent with a two (2) person physical assist. The facility Investigation Summary documented, on 05/30/2025, Resident #1 sustained a fall from bed witnessed by Certified Nurse Aide #10, who had performed care on them minutes earlier. The fall resulted in L1 and L2 lumbar (top two (2) vertebrae in the lower back) process fractures (break) and laceration (open wound) to the posterior (back of) scalp. The investigative findings documented that during an interview with Certified Nurse Aide #10, they stated they were preparing the draw sheet to change it, but was not yet in the process of turning and positioning the resident when the resident rolled off the bed and they were unable to stop the resident from falling. The nurse and nurse supervisor were notified, the physician and family were notified. The resident was sent to the hospital and was admitted due to an L1 and L2 lumbar transverse process fracture and received sutures to the posterior scalp. The report documented it was determined Certified Nurse Aide #10 was preparing to turn and position the resident on their own, despite the resident requiring a two (2) person assist. Certified Nurse Aide #10 was terminated upon the conclusion of the investigation. Certified Nurse Aide #10's written statement, dated 05/30/2025, documented Certified Nurse Aide #10 was aware that the resident required a two (2) person assist, however they did not see or ask if the other aide was available to help them. The resident was on their left side after they finished care, and they saw the draw sheet was soiled underneath the resident. As they went to grab a draw sheet at the end of the bed, the resident rolled off the bed. The hospital physician admission assessment, dated 05/30/2025, documented the resident had a scalp laceration near the shunt with bleeding and reported back pain. The X-rays showed acute fractures in the L1 and L2 transverse process. The review of systems was limited due to resident wincing if moved from side to side. During an interview on 10/09/2025 at 12:38 PM, Certified Nurse Aide #10 stated they were aware the resident required two (2) person assistance but had rolled them in bed by themselves in the past. On 05/30/2025, they were with Resident #1 and changed their brief. When Resident #1 was positioned on their left side, they noticed the draw sheet had a stain on it. When they saw the stain, they did not roll the resident to their back but left them on their left side and went to the bottom of the bed where the clean draw sheet was. At that time, they saw the resident roll off the bed and to the floor. The resident had blood on their head, and they called Licensed Practical Nurse #12. During an interview on 10/09/2025 at 2:48 PM, Registered Nurse Supervisor #9 stated they were called by Licensed Practical Nurse #12 regarding the fall. They were told Certified Nurse Aide #10 was about to change the draw sheet when the resident fell/rolled out of the bed. They did an assessment, suspected there were injuries, and the resident was sent out to the hospital. They stated Certified Nurse Aide #10 should have looked at the record to see if the resident required staff assistance of one (1) or two (2) staff prior to starting cares. During an interview on 10/10/2025 at 9:45 AM, Licensed Practical Nurse #12 stated they were not asked to help Certified Nurse Aide #10 with changing residents that night. It was expected the certified nurse aides would help each other and would organize themselves to be available. Certified Nurse Aide #10 came to them and stated the resident was on the floor</p>		