STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335508	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sky View Rehabilitation & Health Care Center L L C	1280 Albany Post Rd Croton on Hudson, NY 10520

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the recertification survey from 02/24/2026 to 03/03/2026, the facility did not ensure a safe, sanitary, homelike environment for residents. This was evident for two (2nd and 3rd Floor) of four resident units during observations of the environment. Specifically, 1) wheelchairs on the 2nd and 3rd Floors were observed soiled with an accumulation of dried and crusted food particles; 2) the 2nd floor had dusty fans, a stained feeding tube pump, and a dining room with stained window shades, sagging wallpaper, and damaged windowsills; and 3) the 3rd floor resident rooms and bathroom doors/walls were observed with dried rust-colored stains/scratches, peeled wall paper, chipped sheetrock, stained ceiling and a broken drawer handle. Findings include: Facility policy titled Wheelchair Cleaning Housekeeping Department revised 1/1/2019 documented the facility will ensure each resident's wheelchair is washed on a regular quarterly basis, or more often as clinically appropriate and/or determined by members of the interdisciplinary team. Facility policy titled Preventative Maintenance Maintenance/Environmental Services Department, revised 2/9/2023, documented personnel are required to describe faults, report malfunctions and make recommendations for improved maintenance equipment inspection. A log will be available 24/7 on each nursing unit and other areas as needed. 1)Wheelchair observations: During an observation on 2/25/2026 at 3:13PM, Resident #13 was in the 2nd floor day room in their wheelchair. The wheelchair was observed to be caked with old food on the large wheels. During observations on 02/25/2026 at 11:10 AM and 3:51PM; 02/26/2026 at 12:50PM; and 3/1/2026 at 11:45AM, Resident # 3 was in the 3rd floor day room sitting in a wheelchair. The wheelchair had stains on the metal bars and leg rest covers; and the left brake handle cover was torn. When interviewed on 03/02/2026 at 1:04 PM, the Director of Housekeeping stated housekeeping staff was responsible for wheelchair cleaning. Wheelchair cleaning was scheduled once a month. The wheelchairs were cleaned in the shower rooms on the unit during evening shift, and during wheelchair cleaning, housekeeping staff checked for rips and tears. 2) Second floor observations: During observations on 02/27/2026 at 11:26 AM and 12:53 PM, the 2nd Floor dining room had one of three windows with dried brown food particles and stains. The windowsill to the left of the entrance (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was cracked with a large six-foot section separating from the wall. The wallpaper throughout the room sagged and was separated from the wall at multiple different areas. room [ROOM NUMBER] had a tube feeding pump stained with dried formula. Dusty fans were observed at the nursing station and in room [ROOM NUMBER]. When interviewed on 03/02/2026 at 1:34 PM, the Director of Housekeeping stated they were unaware of the stained window shade in the dining room. The housekeeping department had a schedule for cleaning the general environment in the floor dining room but did not include window dressings in routine general cleaning of the area. When interviewed on 03/02/2026 at 1:40 PM, the Assistant Director of Maintenance stated the 2nd Floor dining room was part of a focused repair project in 11/2025. Maintenance worked on target areas throughout the facility every quarter to ensure concerns with the wallpaper and other environmental conditions were addressed. The Assistant Director of Maintenance stated they were unaware the wallpaper was sagging off the wall or that the wooden windowsill was damaged and loose. Unit staff did not report any repair concerns related to these areas in the logbook located on each unit. 3) Third floor observations: During observations on 02/24/2026 at10:03 AM and 03/02/2026 at 12:00 PM, in room [ROOM NUMBER] the bottom of the bathroom door was warped, and wallpaper was peeled off. The dry wall had deep gouges and plaster was showing. There were brown stains on the ceiling and walls. During observations on 02/25/2026 at 2:36 PM and 03/02/2026 at 11:57 AM, room [ROOM NUMBER], the bathroom wall/door had chipped/peeled plaster; the baseboard was peeled/chipped with brown and black discoloration, the drawer handle of the bottom drawer was broken, and the closet wall was warped with scattered chipped areas. When interviewed on 03/02/2026 at 11:40 AM, Certified Nurse Aide #5 stated there was a maintenance log book at the nurses station where staff wrote environmental concerns such as a bed or television remote not working, issues with light/water, and stripped floors. They also informed maintenance staff when they were on the unit. Maintenance staff usually came to the unit daily and checked the maintenance book. When interviewed on 03/02/2026 at 12:39 PM Licensed Practical Nurse Unit Manager#6 stated housekeeping cleaned the wheelchairs and maintenance did the repairs of broken items and wall repairs. There was a maintenance book in the unit that documented areas for repairs. Maintenance staff checked the book regularly. When interviewed on 03/02/2026 at 12:49 PM, the Director of Maintenance stated they did room checks quarterly on each floor, unit maintenance books were checked three times a day at 8:00 AM, 12:00 PM and 3:00 PM. The Director of Maintenance stated they were aware of the peeled wallpaper, stained ceiling and rust - colored discoloration of bathroom doors/walls. The Maintenance Director checked the 3rd floor maintenance book and confirmed that the last entry was on 02/24/2025 regarding no water in room [ROOM NUMBER]. There were no entries of repairs needed for bathroom doors/walls or broken drawer handle covers. The Director of Maintenance stated they were not aware of a broken drawer handle in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When interviewed on 03/03/2026 at 8:13 AM, the Administrator stated that facility was aware of room repairs needed. Maintenance staff was responsible for repairs of broken items. Maintenance should be checking the unit binder regularly for maintenance repairs. 10 NYCRR 415.5(h)(2)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interviews during the recertification survey 02/24/2026 to 03/03/2026, the facility did not ensure Certified Nurse Aide performance reviews were completed at least once every 12 months. Specifically, four (4) of five (5) Certified Nurse Aides (#1, #2, #3, #4) did not have a performance review documented at least once every 12 months. The findings include:The facility policy and procedure titled Performance Reviews and 12-hour Education for Certified Nurse Aides dated 8/1/2023 documented a performance review for Certified Nurse Aide is completed once every 12 months. The facility was asked to provide Performance Reviews for five (5) Certified Nurse Aides. There was no record of an annual Performance Review for Certified Nurse Aide #1 who was hired on 1/30/2025, Certified Nurse Aide #2 who was hired 2/10/2022, Certified Nurse Aide #3 who was hired 2/13/2019, and Certified Nurse Aide #4 who was hired 12/12/2012. During an interview on 02/25/2026 at 12:13 PM the Human Resources Director stated each department head was responsible for ensuring the Annual Performance Reviews were completed. For the Nursing Department the Unit Manager was responsible for completing the performance review timely. The performance reviews were filed in the employee file and they were unaware the reviews were not up to date. They stated an email was sent to the department heads last January reminding them to complete performance reviews at least every 12 months. During an interview on 02/25/2026 at 12:20 PM, the Director of Nursing stated Human Resources was responsible for tracking that performance reviews were completed and filed. They had been completing reviews and had not been able to catch up and ensure they were all completed. During an interview on 02/25/2026 at 12:38 PM, the Administrator stated they were aware performance reviews should have been completed every 12 months. The facility was completing them annually based on the hire date and was behind. The Director of Nursing was responsible for ensuring the performance reviews were completed and Human Resources was responsible for the reviews to be filed in the employee files. 10NYCRR 415.26 (c) (2) (iii)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews conducted during the recertification survey from 02/24/2026 to 03/03/2026, the facility did not ensure residents had a right to a dignified dining experience for five (5) of eight (8) residents (Residents #33, #54, #57, #85 and #118) observed during dining. Specifically, Residents #57 and #85 were served lunch 20 minutes after tablemate, Resident #118; and Resident #33 was served lunch 17 minutes after tablemate, Resident #54. Findings include:The Resident's Rights policy dated 02/18/2018 documents that all residents have a right to a dignified existence. The facility will promote the exercise of rights for each resident, including any that face barriers such as communication problems, hearing problems and cognition limits.Resident # 85 had diagnoses including dementia, major depressive disorder and hypertension. The annual Minimum Data Set (an assessment tool) dated 1/13/2006 documented the resident's cognition was severely impaired and the resident required supervision or touch assistance with eating.Resident # 118 had diagnoses including diabetes, major depressive disorder and chronic obstructive pulmonary disease. The annual Minimum Data Set, dated [DATE] documented the resident's cognition was severely impaired and the resident required supervision or touch assistance for eating.Resident # 57 had diagnoses including dementia, chronic kidney disease and hypothyroidism. The annual Minimum Data Set, dated [DATE] documented the resident's cognition was severely impaired and the resident required supervision or touch assistance for eating.Resident # 33 had diagnoses including hypertension, hyperlipidemia and anxiety disorder. The quarterly Minimum Data Set, dated [DATE] documented the resident's cognition was severely impaired and the resident required supervision or touch assistance for eating.Resident # 54 had diagnoses including dementia, hyperlipidemia, and hypertension. The admission Minimum Data Set, dated [DATE] documented the resident's cognition was moderately impaired and the resident required set up or clean up assistance with eating.During a dining observation on 02/27/2026 from 11:53 AM to 12:40 PM, Residents #85, #118 and #57 were seated at the same table for lunch. Resident #118 received their lunch tray at 12:14 PM and started eating while Residents #57 and #85 waited. Resident #57 received their lunch tray at 12:34 PM and Resident #85 received their tray at 12:36 PM. At another table, Residents #33 and #54 were seated together. Resident #54 received their lunch tray at 12:16 PM and Resident #33 received their lunch tray at 12:36 PM.During an interview on 02/27/2026 at 11:57 AM Registered Nurse # 9 stated the residents ate at different times as the kitchen first sent the trays for the residents that live on the east side of the floor, and trays for the residents who lived on the west side of the floor were sent later. They also stated there was an earlier food truck that arrived at 11:30 AM for residents who needed assistance with eating.During an interview on 03/03/2026 at 12:35 PM, Licensed Practical Nurse/Unit Manager # 8 stated that they sat the residents according to who they got along with, rather than the time their trays arrived. They stated they had noticed that residents at the same table were being served at different times, and they intended to speak to the kitchen staff.10 NYCRR 415.3(d)(1)(i)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review during the recertification survey from 02/24/2026 to 03/03/2026, the facility did not ensure residents who required dialysis (a process that filters the blood for people in kidney failure) received such services consistent with professional standards of practice for one (1) of two (2) residents (Resident # 4), reviewed for dialysis. Specifically, Resident # 4 received hemodialysis treatments at a community- based dialysis center and the facility did not have on-going communication with the dialysis center including assessments and oversight before and after dialysis treatments. Additionally, the facility was unaware the dialysis center documented the resident was on a fluid restriction.The findings include: The Hemodialysis policy and procedure, revised 01/09/2018, ensures essential resident care information is shared using the communication book at the nurses' station, labeled with the resident's name. The book accompanies the residents to each dialysis treatment. Information may include changes in vital signs, appetite, labs, wounds, consultations, medications, tests, and behaviors. The interdisciplinary team may write in the communication book. After each dialysis treatment, the licensed nurse reviews the book and communicates pertinent information in the 24-hour report and to the nursing supervisor, nurse manager, and physician.Resident # 4 had diagnoses including end stage renal disease, hypertension, and diabetes mellitus. The 02/14/2026 Minimum Data Set (an assessment tool) documented the resident was cognitively intact and required hemodialysis treatments.The Comprehensive Care Plan dated 11/04/2025 documented the resident had renal failure and required hemodialysis on Monday, Wednesday, and Friday, with pick-up time at 1:15 PM.The physician's orders, renewed on 02/06/2026, documented hemodialysis on Monday, Wednesday, and Friday, with chair time at 2:15 PM and ambulette pick-up at 1:15 PM.Resident #4's dialysis communication book was a binder that contained facility generated forms with the facility logo on top. There were three sections to the form. The first section was for facility staff and included date/time, sign and symptoms check boxes, vital signs and a line for signature by the registered nurse or licensed practical nurse. The second section was the dialysis center nurse to complete and included places to record weight and vital signs before and after treatment, catheter site and condition, a line for comments, followed by a line to be signed and dated by the dialysis nurse. The third section was for the facility nurse to sign that the form was reviewed upon return from dialysis. Review of the dialysis communication forms revealed: on 01/21/2026, the facility nurse documented vital signs and signed off, the dialysis center completed their section and signed off; the facility nurse did not sign off for reviewing upon return. On 01/24/2026, the facility documented Resident #4's vital signs, but the facility nurse did not sign; the dialysis center completed their section and signed off; the facility nurse did not sign off for reviewing upon return. On 01/30/2026 the facility and dialysis center completed and signed their sections; the facility nurse did not sign off for reviewing upon return. There were no dialysis forms found in the binder after 01/30/2026. The dialysis center documented their findings on blank sheets of paper on 02/02/2026, 02/04/2026, 02/06/2026, 02/09/2026, 02/11/2026, 02/13/2026, 02/16/2026, 02/19/2026, and 02/25/2026. There was no documented communication on part of the facility or evidence the dialysis center notes were reviewed. The dialysis center notes on 02/11/2026 and 02/19/2026 included documentation that the resident was to remain on a renal diet and fluid restriction, fluid intake should be 1000 milliliters total per day.During an interview on 02/27/2026 at 4:18 PM, Resident #4 stated that the dialysis communication book was taken to each dialysis session and remained with them after each dialysis session. Resident #4 stated the staff were expected to collect the communication book upon their return from dialysis, however, the book was not collected or reviewed by staff when they returned. Resident #4 stated staff did not consistently take their vital signs prior to going to dialysis. During a telephone interview on 03/02/2026 at 11:40 AM, the dialysis center registered nurse stated the facility did not consistently complete the dialysis communicate forms including the resident's vital signs. They stated the last documented vital signs from the (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility for Resident #4 were on 01/30/2026 and after that, they did not provide the communication form, so the dialysis center wrote the information on a blank piece of paper and sent it back to the facility in the resident's binder. They stated the facility had not called to give additional information that was not documented in the communication book.During an interview on 03/03/2026 at 08:13 AM, Licensed Practical Nurse Unit Manager #6 stated that a communication book was available for the facility nurse to record the resident's vital signs before sending the resident to the dialysis center. The communication book was kept in the resident's bag and went to dialysis with the resident. During the interview, Licensed Practical Nurse Unit Manager #6 asked the resident for the communication book; the resident identified the blue binder as the one taken to the dialysis center. Licensed Practical Nurse Unit Manager # 6 reviewed Resident # 4's binder and stated it was disorganized. They stated the facility had contact with the dialysis center and no issues had been reported. During an interview on 3/3/2026 at 10:15 AM, the Registered Dietitian, stated they occasionally communicated with the dialysis center staff, and that any recommendations from the dialysis center would be relayed to the resident's physician. They stated they were unaware of any fluid restriction in place for the resident. They stated the resident remained stable related to their diet.During an interview on 03/03/2026 at 10:23 AM, the Assistant Director of Nursing stated facility nurses were required to check the resident's dialysis site daily for any redness or changes and to report any changes to the resident's physician. Nurses were also required to document the resident's vital signs and any changes in the communication book. The communication book was kept in the facility and accompanied the resident to dialysis. Upon the resident's return to the facility, the nurses should have reviewed the communication book, took vital signs, checked the catheter site for bleeding, and documented the vital signs on the resident's medication administration records.10 NYCRR 415.12 (k)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations interviews and record conducted during the recertification survey from 02/24/2026 to 03/03/2026, the facility did not ensure drugs and biologicals were maintained in accordance with currently accepted professional standards for storage. Specifically, Resident #128 had bottles of Aspirin, Tums, Tylenol and Vitamin B3 that were stored at their bedside.Findings Include:The Medication Storage policy dated 04/15/2018, documents the medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Medications are stored at proper temperatures and locked at all times except when under the direct supervision of staff.Resident # 128 had diagnoses including hypertension, major depressive disorder and vitamin D deficiency. The quarterly Minimum Data Set (an assessment tool) dated 1/13/2026 documented the resident's cognition was intact. The physician's order dated 01/20/2026 documented that the resident/representative deferred self-administration of medication to nursing staff.The physician's order dated 1/20/2026 documented enteric coated aspirin 81 milligram tablet, delayed release, give one tablet (81 milligrams) by oral route once daily.The physician's order dated 1/20/2026 documented vitamin D3 (1000 units) tablet, give one tablet by oral route once daily.The physician's order dated 02/13/2026 documented acetaminophen 325 milligram tablet, give two tablets by oral route every 6 hours as needed.During observations on 02/24/2026 at 11:00 AM and on 02/27/2026 at 9:41 AM, containers of Aspirin, Tums, Tylenol and Vitamin D3 were stored on a shelf in Resident #128's room, next to their bedside.During an interview on 02/27/2026 at 3:43 PM, Registered Nurse Unit Manager #8 stated that the medications stored at the bedside must have been brought in by the resident's family member. They stated that the medications were supposed to be stored in the medication room. Additionally, they stated that they did not know why the nursing staff did not see the medications being stored at the bedside.During an interview on 3/2/2026 at 2:35 PM, Registered Nurse #9 stated that medications should be stored in the locked medication cart and/or the medication room. They stated medications should not be stored at the residence bedside, not even over the counter medications. They stated that they did not notice the medications at the bedside. Additionally, they stated it was important to monitor what residents were taking, as some medications could interfere with other medications and cause an adverse effect. 415.18(e)(1-4)