

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER Waterview Hills Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 537 Route 22 Purdy Station, NY 10578	
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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review, and interviews, the facility failed to ensure that residents are free from significant medication errors for one of four residents (Resident #94) reviewed for hospitalization. Specifically, on 05/04/2025 at 9:00 AM and 9:00 PM, the facility failed to administer Levetiracetam (Keppra: medication used to help control seizures) 750 milligrams two tablets (1500 milligrams) every 12 hours to Resident #94 as per physician order. Subsequently, Resident #94 had a seizure on 05/05/2025 at approximately 12:20 AM and was transferred to the hospital. This resulted in actual harm to Resident #94 that was not Immediate Jeopardy. The findings include: The facility's policy Medication Administration revised 03/05/2024, documented medications should be administered in a safe and timely manner, as prescribed. Medications must be administered in accordance with the orders, including any required time frame, and within one hour of their prescribed time unless otherwise specified (before and after meals). The facility's policy Reordering/Refill revised 03/12/2024 documented medications should be ordered, reordered, and received from the dispensing pharmacy on a timely basis. Resident #94 had diagnoses including epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures), nontraumatic intracerebral hemorrhage (bleeding into the brain tissue), and hepatic encephalopathy (decline in brain function that is caused by severe liver disease). The quarterly Minimum Data Set (a resident assessment tool) dated 03/10/2025 documented Resident #94 was cognitively intact and received anticonvulsant medications for seizures. The Care Plan for seizure disorders, revised 03/15/2025 documented Resident #94 was to be maintained on anti-seizure medication with the goal to maintain therapeutic levels of medication to prevent seizure activity. The Physician Order dated 04/16/2025 documented Keppra 750 milligram tablets, two tablets (1500 milligrams) by oral route every 12 hours for seizures, at 9:00 AM and 9:00 PM. The Physician Order dated 04/16/2025 documented seizure precautions in place every day from 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. The May 2025 Medication Administration Record documented on 05/04/2025 Keppra 750 milligram tablet, two tablets (1500 milligrams), were to be administered at 9:00 AM and 9:00 PM. Both doses were documented as given at 11:07 PM. The Investigation Summary dated 05/05/2025 documented on 05/05/2025 at approximately 12:20 AM, Resident #94 was observed with generalized seizures for one minute and was placed on their side. Afterwards, Resident #94 was unresponsive for a couple of minutes, with oxygen saturation at 97%. Temperature was 98.4 and increased to 99.2. Resident #94 regained consciousness was alert and verbal, but extremely restless in bed. The physician was notified and ordered a transfer to the emergency room. Resident #94's representative was made aware. Resident #94 was sent to the emergency room at 12:45 AM via emergency medical services and was admitted with a diagnosis of seizures. During a chart review by Registered Nurse Supervisor #10 on 05/05/2025, it was observed that Resident #94's Keppra was signed as being administered at 11:07 PM. Registered Nurse Supervisor #10 informed Registered Nurse Manager #12, who stated they would investigate. On 05/06/2025, Registered Nurse Manager #12 spoke with Licensed Practical Nurse #8 regarding the Keppra doses that were signed late. Registered Nurse Manager #10 re-educated Licensed Practical Nurse #8 about signing for Keppra at the time of administration. During a morning report on 05/09/2025, there was a discussion about Resident #94 returning to the (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 0760 Level of Harm - Actual harm Residents Affected - Few	facility and a review of hospital documentation from the resident's family, who stated that in the past, when the resident missed or was given their seizure medication late, Resident #94 would have a seizure. The Director of Nursing interviewed Licensed Practical Nurse #8 on 05/09/2025, who initially stated they forgot and signed the Keppra doses late, then informed the Director of Nursing that the Keppra was not available on the medication cart for the AM/PM doses. Licensed Practical Nurse #8 stated they signed for both doses of Keppra that were not available and did not notify the nurse supervisor, the physician, or the pharmacy. Licensed Practical Nurse #8 was suspended on 05/09/2025 pending investigation and was terminated on 05/12/2025. There was no documented evidence in the electronic medical record on 05/04/2025 to indicate that the medical provider was made aware that Keppra was not available and/or administered to Resident #94. The progress note dated 05/05/2025 at 4:43 AM entered by Registered Nurse Supervisor #9 documented that Resident #94 was admitted to the hospital with a diagnosis of seizures. The progress note dated 05/11/2025 at 10:20 PM entered by Registered Nurse Supervisor #9 documented that Resident #94 was re-admitted at 3:30 PM with a diagnosis of seizures. During a telephone interview on 06/04/2026 at 12:39 PM, Licensed Practical Nurse #8 stated that Resident #94's Keppra was not available on 05/04/2025. When they checked the record, they observed it had been reordered, though they could not recall the date it had been reordered. They stated they did not notify the supervisor that they did not have Resident #94's Keppra. Licensed Practical Nurse #8 stated they should have notified the nursing supervisor that the Keppra was not available and that it did not arrive on the evening of 05/04/2025. They stated they worked 16 hours that day and although Keppra was not available, they documented that the AM and PM doses of Keppra were given. They stated they were waiting for the pharmacy to deliver Keppra; once it arrived, they would give the PM dose to Resident #94. They stated that they did not inform Resident #94 that their Keppra was unavailable. They stated they gave all other medications to Resident #94 and that Resident #94 showed no signs or symptoms of distress and did not have a seizure during their shift. During an interview on 06/04/2026 at 1:23 PM, the Director of Human Resources stated that Licensed Practical Nurse #8 was hired on 09/07/2021 and terminated on 05/12/2025. They stated that Licensed Practical Nurse #8 was suspended pending an investigation conducted on 05/09/2025. They stated because Licensed Practical Nurse #8 documented that Keppra was administered when it was not available, they were reported to the Board of Professional Licensing. During a telephone interview on 06/05/2026 at 12:57 PM, Registered Nurse Supervisor #9 stated that on 05/04/2025, they heard a noise from Resident #94's room and found Resident #94 in bed, shaking and drooling. They stated Resident #94 was turned to the side and had a seizure lasting one minute, after which they remained unconscious, but responded after the seizure. They stated Resident #94 was sent to the emergency department and admitted for a seizure. They stated they were unaware of the missed Keppra as it was signed off as given. They stated that when Resident #94's family was notified, they asked about the Keppra, prompting the supervisor to check the medication record and cart. They stated a blister pack of Keppra was not found in the medication cart. They stated typically, medication was reordered when five days remained in the blister pack. During a telephone interview on 06/08/2026 at 7:48 AM, Resident #94's Representative stated they were notified by the facility that Resident #94 had a seizure. They stated they asked the supervisor if Resident #94 received the Keppra, because they had spoken with Resident #94 at 8:00 PM that day, and Resident #94 told them they had not received the Keppra. They stated Registered Nurse Supervisor #10 told them the administration of Keppra was signed for after 11:00 PM. They stated in the past after each episode of seizures it took Resident #94 two to three months to return to baseline. During a telephone interview on 06/08/2026 at 10:20 AM, Pharmacist #2 stated that the facility ordered medication refills by phone, fax, or through electronic medical record. They stated that on 03/24/2025, a month's supply of Keppra (120 tablets) was sent to the facility. Pharmacist #2 stated they could not find a May 2025 request for Resident #94's Keppra, therefore, there were no deliveries of Keppra for Resident #94 until 05/11/2025. Pharmacist #2 stated they delivered to the (continued on next page)		

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F 0760 Level of Harm - Actual harm Residents Affected - Few	facility two times each day, including weekends. They stated on 05/15/2025, 10 tablets of Keppra 250 milligrams were supplied in the Cubex machine (system for emergency use medication cabinet). During an interview on 06/08/2026 at 10:44 AM, Physician #1 stated they had been informed that Resident #94 experienced a seizure, and they ordered transfer of Resident #94 to the hospital for evaluation. They stated they were told that Resident #94 did not receive both doses of Keppra that day. They stated they did not receive a call from the nurse related to the Keppra not being available. They stated they would have expected the nurse to call and say the Keppra was not available. They stated that when Resident #94 did not receive their Keppra, it caused harm resulting in Resident #94 having a seizure. They stated the harm was not permanent. They stated the facility took appropriate action, sent Resident #94 out to the emergency room, and after hospitalization, followed up with neurology. They stated Resident #94 was currently doing well. During an interview on 06/08/2026 at 3:51 PM, Licensed Practical Nurse #11 stated they used the last two Keppra tablets and reordered the Keppra on 05/02/2026 using the electronic system. They stated the Keppra was expected to arrive that evening. Licensed Practical Nurse #11 stated they were off the next day and did not follow up on the delivery of Keppra. During a follow-up telephone interview on 06/09/2026 at 8:49 AM, Physician #1 stated they wanted to clarify that because Resident #94 did not receive their seizure medication, the effect was they had a seizure. During an interview on 06/09/2026 at 9:52 AM, the Director of Nursing stated they followed up with Licensed Practical Nurse #11, who reported using the last two Keppra tablets and reordering the medication through the electronic system on 05/02/2026. They stated they could not locate in the electronic medical records to indicate that Keppra was reordered on 05/02/2025. They stated Licensed Practical Nurse # 8 signed off on the Keppra administration on 05/04/2025. They stated when speaking to License Practical Nurse #8, they told them that they believed they gave the Keppra to Resident #94 on 05/03/2025. The Director of Nursing stated after the incident with Resident #94, Keppra was added to the Cubex system, and all nurses were re-educated on timely medication sign-off and procedures for missing medications, including calling the pharmacy or supervisor. During the onsite survey, past noncompliance was cited (F760) after the facility was able to demonstrate the following actions were implemented to correct the noncompliance as of 05/15/2025: QAPI meeting was held on 05/09/2025. The policy and procedures for medication administration, unavailable medication process, and medication reordering documented 100% reviewed by all nurses. Staff education medication administration, unavailable medication process, medication reordering and refill process, medication error prevention, seizure management, falsification of documentation, and correct channels of communication documented completed by 100% of all nurses. Audits daily unavailable medications, staff knowledge for medication management, medication administration and staff knowledge of medication administration. Ongoing QAPI for six months/year as outlined (medication administration competency, staff knowledge of medication error prevention, refill process, and unavailable medication process). Daily check of the involved residents MAR and medication supply to ensure timeliness of medication administration and no unavailable medications. The facility was able to demonstrate monitoring of the corrective action and sustained compliance. 10 New York Code Rules Regulations 415.12(m)(2).		