

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Hilltop Village Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Hilltop Rd Kerrville, TX 78028	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>47611</p> <p>Based on interview and record review, the facility failed to ensure residents had the right to be free from verbal abuse for 3 of 7 residents (Residents #1, #2, and #3) reviewed for abuse.</p> <ol style="list-style-type: none"> The facility failed to prevent RN A from verbally abusing Resident #1 and Resident #2 when RN A yelled at both residents. The facility failed to protect Resident #3 when OT called resident a liar and yelled at her. <p>These failures could place residents at risk of verbal abuse from facility staff.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Record review of the Facility Incident Report, dated 3/22/2024, reflected RN A was witnessed telling Resident #1, I want to spray you with Ativan spray because you are getting on my nerves. Furthermore, it was also witnessed that RN A told Resident #2 that you can't get your ass clean or your shit because the girls are busing feeding. Record review of Facility Incident Report, dated 12/15/2023, reflected OT yelled and called Resident #3 a liar. <p>During an interview on 6/28/2024 at 10:18 am with CNA B, she stated that Resident #1 was just asking questions when she witnessed RN A became upset and yelled at Resident #1. CNA B also witnessed RN A tell Resident #2 that you can't get your ass clean or your shit because the girls are busing feeding.</p> <ol style="list-style-type: none"> Record review of Facility Incident Report, dated 12/15/2023, reflected OT yelled and called Resident #3 a liar. <p>During an interview on 6/28/2024 at 9:04 am with PTA staff, she stated she was present and witnessed the altercation between OT and Resident #3. She stated when Resident #3 was talking about her past employment history, OT called her a liar and then proceeded to call Resident #3's employer to verify past employment. Resident #3 became upset that OT called her a liar and called her previous employer.</p> <p>During an interview in 6/28/2024 at 11:10 am with ADMN, she stated that abuse is not tolerated and that she was not familiar with the incidents in question as they happened prior to her employment at the facility as the facility had a recent change in ownership.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Abuse and Neglect Policy dated 5/1/13 revealed The facility's leadership prohibits neglect, mental, physical and/or verbal abuse of any resident .</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>47611</p> <p>Based on interview and record review, the facility failed to ensure each resident was free of any significant medication errors for 1 of 7 residents (Resident #4) reviewed for medications.</p> <p>-The facility failed to provide Resident #4 with Doxycycline (an anti-infective).</p> <p>This deficient practice could result in a risk to the residents' health and complications which can lead to infection.</p> <p>The findings included:</p> <p>Record review of the Facility Incident Report, dated 4/22/2023, reflected LVN C transcribed Resident #4's medication orders. The order for Doxycycline was 100 mg BID X 21 days for epididymitis (inflammation on a coiled tube behind the testes). When LVN C transcribed the order, she entered the order to read every 21 days instead of for 21 days. This resulted in Resident #3 missing 25 doses from 4/4/2023 to 4/16/2023.</p> <p>Record review of Resident #4's MAR showed no Doxycycline medication administration from 4/2/2023 to 4/26/2023.</p> <p>Record review of Resident #4's doctors Notes, dated 4/15/2024 showed Trial of doxycycline for possible epididymitis. I discussed with the patient that this combination of groin pain and leg pain is likely neurological and not related to any abnormalities as his physical exam is essentially normal.</p> <p>Interview on 7/1/24 at 9:47 am with DON - verified resident MAR was missing medication doses for the dates in question. She stated she was not the DON at the time of the incident as the facility recently had a change of ownership.</p> <p>Record review of facility policy titled, Medication Administration, dated revised January 2024, reflected Resident medications are administered in an accurate, safe, timely, and sanitary manner . administer medications as ordered by the physician. Routine medications shall be administered according to the established medication administration schedule for the community .</p>