STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455628	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Village Nursing and Rehabilitation	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)
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 interview and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promoted maintenance or enhancement of quality of life, recognizing each resident's individuality for 1 (Resident #1) of 7 reviewed for dignity. The facility failed to ensure CNA A treated Resident #1' room, supplies and personal space with respect. This failure could place the residents at risk of feeling uncomfortable, disrespected and could decrease residents' self-esteem and/or diminished quality of life. The findings included: Record review of Resident #1's face sheet, dated 5/29/2025 revealed a [AGE] year-old female admitted on [DATE] with diagnoses which included: chronic obstructive pulmonary disease, major depressive disorder recurrent, and generalized anxiety disorder. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact with no behaviors documented. The assessment revealed Resident #1 required supervision for showering and set up assistance for dressing. Record review of Resident #1's Care Plan for ADL self-care last updated 1/31/2024 revealed the resident required supervision and set up by one staff member for showering and supervision and sept up by one staff member to dress. Record review of Resident #1's Care Plan for behavior problem last updated 5/01/2025 revealed Resident refuses to wait for assistance to shower. She has been noted to hoard towels and bed linens with interventions which included: caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her as passing by, If reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention .Monitor behavior episodes and attempt to determine underlying cause. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Form 3613-A Provider Investigation Report dated 5/21/2025 revealed Resident #1 stated in the hallway to CNA A you hit me. Resident #1 indicated she was upset the CNA (CNA A) removed a stack of towels from her room. CNA A was suspended pending investigation, a head-to-toe assessment was completed with no findings and an investigation was completed. The results of the investigation were inconclusive. During the investigation, the report indicated Resident #1 did not want CNA A fired, she just wanted her taken off the hallway. Record review of a typed statement signed by the DON and ADON, dated 5/21/2025 revealed she interviewed Resident #1 about her allegation that CNA A hit her. The document stated the resident was unable to give details regarding the incident and stated she was upset the CNA took multiple towels out of her room as resident will shower self. Resident also stated she just wants this CNA on a different hall. The resident was notified the incident was reported to the administrator and state to which she replied I don't care. I just want my towels back. Record review of a written statement documented by CNA A, dated 5/21/2025, CNA wrote she was walking down the hallway when Resident #1 stuck her arm out and bumped into her arm. She stated as she was walking away Resident #1 stated don't hit me. CNA A wrote on 5/20/2025 she took some towels out of Resident #1's room, then at smoke break the resident told CNA to go to hell. During an interview on 5/29/2025 at 2:45 p.m., CNA A stated on a Tuesday (5/20/2025) she took towels out of Resident #1's room because they were short on towels. She stated when they were short on towels, they would do a room sweep. She stated she removed a 1/2 barrel of towels or approximately 10 towels from Resident #1's room. She stated later the same day, Resident #1 looked at her and said, Go to hell. CNA A stated she did not do anything, did not respond, and just ignored it. CNA A stated on Wednesday (5/21/2025) she was just walking normal down the hall. She stated Resident #1 was passing by her. CNA A stated her hands were by her side and she was walking normal. She stated Resident #1 stuck out her arm and yelled stop hitting me. CNA A stated she felt like Resident #1 purposely bumped into her in her wheelchair. CNA A stated she told her nurse, LVN D that Resident #1 was going around telling people that she hit her. CNA A stated the DON came and got her immediately, asked her to write and statement and sent her home while they investigated. CNA A stated she did not tell the resident prior to taking the towels out of her room and did not ask for permission. She stated she knew Resident #1 was outside on a smoke break. CNA A stated she did not ask the resident because Resident #1 will go to other hallways and ask staff for towels. She stated the staff will give the towels to the resident and she just keeps stacking them up. CNA A stated she removed all of the facility towels and did not leave any of them. She stated she did leave the resident's personal towel. CNA A stated she did not want to leave any towels for Resident #1 because they do not know when the resident showers and she will go in the shower alone in her room even though they have asked her to wait for supervision. CNA A stated this was not the first time she had removed towels and felt like the resident was mostly okay with it, but something triggered her this time. CNA A stated she had been trained to know and ask if it was alright to enter and to take something. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 3:47 p.m., Resident #1 stated she did not remember making an allegation that CNA A hit her. She stated she did not remember CNA A hitting her or making any allegation of hitting. She stated she did not like CNA A because she walked around like a buffalo. She stated CNA A was only ugly to her and only she could see it because CNA A was not like that to anyone else. Resident #1 stated she was upset with CNA A because she took her briefs, and she took towels out of her room which upset her. She stated CNA A did not ask her before she took the items. Resident #1 stated it made her feel upset because she did not know why CNA A was in her room or why she was taking her things. She stated CNA just did it and she did not know why. Resident #1 stated she never wanted to see CNA A again. She stated she had not talked to anyone at the facility about her frustration. During an interview on 5/29/2025 at 3:56 p.m., CNA A stated three days prior to taking the towels she had taken three stacks of briefs out of Resident #1s room. She stated she left one stack for Resident #1 to use. She stated she told the resident she was taking them because she needed the briefs, and she thought Resident #1 was okay with it. CNA A stated the next day Resident #1 went and asked for more which frustrated CNA A because staff gave them to her. CNA A stated Resident #1 had hoarding tendencies. She stated it was nothing new. She stated she would not let staff take anything out of her room. She stated she took the briefs and took the towels because the facility needed them. CNA A stated she had not received direction by anyone to take the items. She stated she did not tell anyone of her intention to take them. CNA A stated she had been trained in resident rights. She stated the facility was the resident's home and they had rights and that it was their belongings. CNA A stated she thought it was excessive that Resident #1 used 5-6 towels, 4 washcloths and 2 shower blankets per shower. She stated that was what Resident #1 always asked for, that was her routine but there was no reason the resident needed that many towels. CNA A stated she was not sure what the facility policy indicated she should do if the resident was not in her room. She stated Resident #1 always kept her room door shut. CNA A stated he knocked before entering but knew Resident #1 was on a smoke break and not in her room when she took the items. During an interview on 5/29/2025 at 5:26 p.m., LVN D stated on 5/21/2025 towards the end of shift at an unknown time, CNA A told her Resident #1 stated she had hit her. LVN D stated she interviewed Resident #1 said CNA A hit her three times on the arm and demonstrated with three pats to her upper arm/shoulder. LVN D stated she observed the skin and did not see any redness or marks and Resident #1 denied any pain. LVN D stated Resident #1 was not able to provide any details, including date or time the incident occurred. LVN D stated Resident #1 told the DON the same thing and again was not able to provide the date or details. LVN D stated Resident #1 does have a history of getting upset at little things. LVN D stated this was not the first time CNA A has removed towels from Resident #1's room. She stated she has also had a discussion with CNA A about the towels and showers. LVN D stated she told CNA A and other staff they cannot take the towels away, that all they could do was document when she took showers and try to educate the resident. LVN D stated she did not instruct CNA A to take briefs or towels out of Resident #1's room. She stated they cannot reuse the briefs and they have to be discarded. She stated briefs should not be taken out of a resident room. LVN D stated there was no nursing direction to the CNAs to take towels out of any rooms on that day. She stated she thinks CNA A removed the towels so Resident #1 could not shower. LVN D stated the facility has plenty of briefs and towels. She stated Resident #1 does have hoarding tendencies. She stated like she has told CNA A before, she cannot just take things out of a resident room without permission. She stated she told her staff, this was not jail, everyone has rights, residents have a right to utilize facility stuff and they are paying for services. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 6:12 p.m., the DON stated LVN D reported to her and the Administrator that Resident #1 was accusing CNA A of hitting her. She stated she completed a head-to-toe skin assessment and there were no alterations in skin. The DON stated she asked Resident #1 what happened, and she was not able to provide any details. She stated Resident #1 did not appear to be in any distress and went at normal time to her smoke break. The DON stated after investigating the incident she believes Resident #1 was upset that CNA A took towels out of her room. She stated Resident #1 showers alone when she was not supposed to, so CNA A took the towels out of her room. The DON stated even if the resident was hoarding, staff still had to ask permission and they try would try to remove some of the items, but they still had to ask. She stated it was important because it was a resident right. She stated the staff should not remove briefs from the room because briefs cannot be used after they have been in a resident room. The DON stated the facility did not have supply issues. She stated she does not know why CNA A would remove the briefs. The DON stated staff should try to find the cause of the hoarding issues but still need to ask staff before moving the items. Record review of a facility policy titled Resident Rights, last revised December 2016 revealed; Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights included the resident's right to a. a dignified existence b. be treated with respect, kindness and dignity. e. self-determination.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report all allegations of abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials in accordance with State law through established procedures for 1 (Resident #7) of 7 residents reviewed for reporting requirements. The DON failed to report to the Administrator and the state survey agency when Resident #7's family reported rough care and treatment. This failure could put the residents at risk of abuse and harm. The findings included: Record review of Resident #7's face sheet dated 5/29/2025 revealed a [AGE] year-old female, admitted on [DATE] and readmitted [DATE] with diagnoses which included: noninfective gastroenteritis and colitis (inflammation of the stomach and colon), generalized muscle weakness and urge incontinence. Record review of Resident #7's modification of 5-day admission MDS assessment dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact. The assessment indicated Resident #7 required maximum assistance with transfers. Record review of Resident #7's Care Plan for ADL self-care last revised on 5/28/2025 revealed the resident required the assistance of one staff member for toileting and transfers. Record review of TULIP on 5/28/2025 revealed there were no facility self-reported incidents for Resident #7. During an interview on 5/29/2025 at 1:25 p.m. with Resident #7 and family, Resident #7 appeared confused to short term memory recall. She was unable to accurately recall what she had for lunch that day. She stated staff checked on her several times during the day and at night and she felt safe in the building with no current concerns. Resident #7's family members #1 and #2 stated they had concerns about CNA B (an agency staff member). Family member #2 stated CNA B sometime last week on an unknown date during the daytime shift assisted Resident #7 to the bathroom. Family member #2 stated the family stepped out into the hallway to give Resident #7 some privacy while the staff took the resident to the toilet. She stated when she was finished toileting Resident #7's face was beat red, she was upset and stated CNA B pushed her down onto the toilet. Family member #2 stated they could tell and felt like something had occurred because Resident #7 was upset. She stated Resident #7 was unable to say exactly what had occurred. Family member #2 stated she went and found a staff member (CNA E). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family member #2 stated CNA E came into the room, got down on Resident #7's level and asked what happened. Family member #2 stated Resident #7 told CNA E exactly she had received rough care. Family member #2 stated the next day they came back to the facility and were surprised to see CNA B at work. She stated this time she went straight to the DON who was in her office and told her what occurred. Family member #2 stated she told them the same thing she had reported today. The family member stated since that date last week, they had not seen CNA B in the facility. During an interview on 5/29/2025 at 2:25 p.m., CNA E who identified herself as the facility scheduler, stated on an unknown date, last week on day shift, Resident #7's family had approached her and stated agency CNA B had taken Resident #7 to the bathroom. They stated there was a gait belt in the room but CNA B stated she did not use one and they stepped out. CNA E stated the family said when they went back in the resident had stated CNA B was very rough with her. CNA E stated she asked Resident #7 what had happened. She stated she was rough with her when she wiped her. CNA E stated she did not say anything else just that she was rough when she wiped. CNA E stated the family reported CNA B told them if they were in the room, they should be helping the resident instead of her. CNA E stated she immediately informed the DON who send CNA B home. CNA E stated they had not had CNA B back at the facility since she was sent home. CNA E stated she had completed abuse training. She stated she knew she had to report abuse to the Administrator immediately. She stated abuse was any harm to the resident. She stated she considered rough care as abuse. CNA B stated she did not tell the Administrator directly. She stated she did not tell the Administrator because the DON told the Administrator. CNA B stated she was instructed by the DON, as the scheduler, she was not to allow CNA back in the building again, so she removed her from the schedule. CNA E stated she did not see any injuries on the resident, but it was the nurses responsibility to do an assessment. She stated Resident #7 was not crying, but she was upset. During an interview on 5/29/2025 at 3:09 p.m., CNA E stated she wanted to correct a mistake on the previous interview. She stated CNA B was not sent home that day. She was allowed to continue to work but she was told to stay away from Resident #7 and she could not go back in the resident rooms. CNA E stated it was the following day, when the family saw CNA E in the building that the DON told her not to allow CNA B back in the building. During an interview on 5/29/2025 at 6:23 p.m., the DON stated Resident #7's family was upset CNA B refused to use a gait belt and was rude. The DON stated rude meant she said no to the gait belt. The DON stated she told CNA E that CNA B could not be assigned to Resident #7. The DON stated the next day, date unknown, the family approached her and asked why CNA B was back in the building and they were very upset. The DON stated she told the family she would take care of it and that CNA B was not assigned to Resident #7. The DON stated she told CNA E to send CNA B home and the facility had not utilized her again because Resident #7 was very upset. The DON stated there were no reports of abuse. She stated it was only reported to her that the family was upset that she did not use a gait belt. She stated she did not talk to the resident directly and did not report to the Administrator because there was no abuse. The DON stated she needed to review her notes and left the interview. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 7:28 p.m., the DON stated CNA E reported to her that Resident #7 was not in any distress. The DON stated it was only reported to her that CNA B was rude and there were no indications of abuse. The DON stated Resident #7 was calm and asleep and she did not speak to her because CNA E had spoken to the resident. The DON stated CNA B did not give her any more specifics. The DON stated she sent CNA B home the next day, because the family was upset and because of her work ethic of not using a gait belt. The DON stated she did not need to report abuse because the family had reported rudeness. She stated she also did not report to the Administrator because again, the family had only reported rudeness and an issue with a gait belt. She stated there were no specifics like yelling, talking back or anything that indicated abuse. During an interview on 5/30/2025 at 8:02 a.m. agency CNA B stated on 5/23/2025 was the date the bathroom situation occurred and 5/24/2025 was the day she was sent home. CNA B stated on 5/23/2025 Resident #7 call light was going off and two people in the room (family) told her the resident needed to go to the bathroom. CNA B stated after the resident finished on the toilet, she was helping the resident transfer from the commode to the wheelchair and the resident's foot got stuck and her knee locked. CNA B stated she told Resident #7 to hold onto the rail. She stated she grabbed Resident #7 by the pants, pulled her up by her pants and helped her to pivot to the wheelchair. CNA B stated Resident #1 got upset and asked why she had stretched her pants. CNA B stated the family complained that she was too rough. She denied abusing the resident or being rough with care. During an interview on 6/02/2025 at 9:22 a.m., the Administrator stated after surveyor intervention on 5/29/2025 she called the Resident #7's family about their concerns. She stated Resident #7's family expressed concerns about CNA B. She stated they said CNA B did not seem self-assured with the use of the gait belt. The Administrator stated after the family went back into the room after the toileting, they reported that CNA B told them the next time the resident needed help, they could help her. The Administrator also reported the agency staff wiped the resident hard per Resident #7. She stated 5/29/2025 was the first time she had heard of the incident when surveyor started asking questions. She stated no one had reported it to her prior to this date. The Administrator stated the DON had responded by removing CNA B from caring for the resident. The Administrator stated CNA E got involved because she was the scheduler and the family originally told CNA E. She stated CNA E then told the DON and the DON responded by removing her from the care of the resident. The Administrator stated since learning of the incident on 5/29/2025 she knows CNA E did not report the incident to her, she reported to the DON. She stated the DON indicated CNA E told her CNA B was very rude, mentioned the gait belt and said she was wiped hard. The Administrator stated the DON strictly recalled the RP saying CNA B was rude but does not recall anything else except being upset about the gait belt. The Administrator stated she did not know what she expected the DON to do. She stated that would have depended on what the DON was told. The Administrator stated she thought the DON handled it appropriately and would not have expected it to be reported based on what she was told. The Administrator stated rudeness was a common complaint made of agency staff. She stated to distinguish rudeness from abuse was based on mental anguish. She stated when they hired agency, they did not know their work ethic. She stated agency staff come with an attitude, but it does not mean it crossed the line into abusiveness. The Administrator stated they did have an abuse policy in place which does require reporting. She stated the staff received abuse training upon hire and annually. She stated they do abuse in-services as issues arise that are specific to the issue at hand. She stated there are keywords such as hard, rough, pain that should be investigated and reported. She stated rough care should be looked at but she could not say if it was or was not abuse. She stated agency staff, such as CNA B did receive abuse training before she was allowed to work on the floor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy, titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating last revised September 2022 revealed: All reports of abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Finding of all investigations are documented and reported. and If resident abuse, neglect, exploitation, misappropriation of resident property, or injury of unknown origin is suspected, the suspiciaion must be reported immediately to administrator and other officials in accordance with State law.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to have evidence all allegations of abuse, neglect or mistreatment were thoroughly investigated and documented for 1 of 9 residents (Resident #7) reviewed for abuse. The facility failed to ensure an allegation of rough care and treatment was investigated and the DON's notes/documentation were retained regarding Resident #7 family complaints of rough care and treatment. These failures could place residents as risk for abuse and neglect by not investigating allegations of abuse, neglect, exploitation, or mistreatment. The findings included: Record review of Resident #7's face sheet dated 5/29/2025 revealed a [AGE] year-old female, admitted on [DATE] and readmitted [DATE] with diagnoses which included: noninfective gastroenteritis and colitis (inflammation of the stomach and colon), generalized muscle weakness and urge incontinence. Record review of Resident #7's modification of 5-day admission MDS assessment dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact. The assessment indicated Resident #7 required maximum assistance with transfers. Record review of Resident #7's Care Plan for ADL self-care last revised on 5/28/2025 revealed the resident required the assistance of one staff member for toileting and transfers. Record review of facility grievances for May 2025 revealed no grievances were documented regarding Resident #7. During an interview on 5/29/2025 at 1:25 p.m. with Resident #7 and her family members, Resident #7 appeared confused to short term memory recall. She was unable to accurately recall what she had for lunch that day. She stated staff checked on her several times during the day and at night and she felt safe in the building with no current concerns. Resident #7's family members #1 and #2 stated they had concerns about an CNA B (an agency staff member). Family member #2 stated CNA B sometime last week on an unknown date during the daytime shift assisted Resident #7 to the bathroom. Family member #2 stated the family stepped out into the hallway to give Resident #7 some privacy while the staff took the resident to the toilet. She stated when she was finished toileting Resident #7's face was beat red, she was upset and stated CNA B pushed her down onto the toilet. Family member #2 stated they could tell and felt like something had occurred because Resident #7 was upset. She stated Resident #7 was unable to say exactly what had occurred. Family member #2 stated she went and found a staff member (CNA E). Family member #2 stated CNA E came into the room, got down on Resident #7's level and asked what happened. The family member stated the Resident told CNA E she had received rough care. Family member #2 stated the next day they came back to the facility and were surprised to see CNA B at work. She stated this time she went straight to the DON who was in her office and told her what occurred. Family member #2 stated she told them the same thing she had reported today. Family member #2 stated since that date last week, they had not seen CNA B in the facility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 2:25 p.m., CNA E who identified herself as the facility scheduler, stated on an unknown date, last week on day shift, Resident #7's family had approached her and stated agency CNA B had taken Resident #7 to the bathroom. They stated there was a gait belt in the room but CNA B stated she did not use one and they stepped out. CNA E stated the family said when they went back in the resident had stated CNA B was very rough with her. CNA E stated she asked Resident #7 what had happened. She stated she was rough with her when she wiped her. CNA E stated she did not say anything else just that she was rough when she wiped. CNA E stated the family reported CNA B told them if they were in the room, they should be helping the resident instead of her. CNA E stated she immediately informed the DON who send CNA B home. CNA E stated they had not had CNA B back at the facility since she was sent home. CNA E stated she had completed abuse training. She stated she knew she had to report abuse to the Administrator immediately. She stated abuse was any harm to the resident. She stated she considered rough care as abuse. CNA B stated she did not tell the Administrator directly. She stated she did not tell the Administrator because the DON told the Administrator. CNA B stated she was instructed by the DON, as the scheduler, she was not to allow CNA back in the building again, so she removed her from the schedule. CNA E stated she did not see any injuries on the resident, but it was the nurses responsibility to do an assessment. She stated Resident #7 was not crying, but she was upset. During an interview on 5/29/2025 at 3:09 p.m., CNA E stated she wanted to correct a mistake on the previous interview. She stated CNA B was not sent home that day. She was allowed to continue to work but she was told to stay away from Resident #7 and she could not go back in the resident rooms. CNA E stated it was the following day, when the family saw CNA E in the building that the DON told her not to allow CNA B back in the building. During an interview on 5/29/2025 at 6:23 p.m., the DON stated Resident #7's family was upset CNA B refused to use a gait belt and was rude. The DON stated rude meant she said no to the gait belt. The DON stated there were no reports of abuse. She stated it was only reported to her that the family was upset that she did not use a gait belt. The DON stated she thought they had done a skin assessment on the resident by a charge nurse but was unable to find it. She stated she was unable to find her notes from the incident after looking through her notes and binders. The DON stated she already shredded the documents. She stated she did not talk to the resident directly and did not report to the Administrator because there was no abuse. The DON stated she needed to review her notes and left the interview. During an interview on 5/29/2025 at 7:28 p.m., the DON stated CNA E reported to her that Resident #7 was not in any distress. The DON stated it was only reported to her that CNA B was rude and there were no indications of abuse. The DON stated Resident #7 was calm and asleep and she did not speak to her because CNA E had spoken to the resident. The DON stated CNA B did not give her any more specifics. The DON stated she sent CNA B home the next day, because the family was upset and because of her work ethic of not using a gait belt. The DON stated she did not investigate the incident because CNA E was the person dealing with the family and CNA B. She stated there was no indication of abuse. She stated she did not interview CNA B or the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455628	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Village Nursing and Rehabilitation	1400 Hilltop Rd Kerrville, TX 78028

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/30/2025 at 8:02 a.m. agency CNA B stated on 5/23/2025 was the date the bathroom situation occurred and 5/24/2025 was the day she was sent home. CNA B stated on 5/23/2025 Resident #7 call light was going off and two people in the room (family) told her the resident needed to go to the bathroom. CNA B stated after the resident finished on the toilet, she was helping the resident transfer from the commode to the wheelchair and the resident's foot got stuck and her knee locked. CNA B stated she told Resident #7 to hold onto the rail. She stated she grabbed Resident #7 by the pants, pulled her up by her pants and helped her to pivot to the wheelchair. CNA B stated Resident #1 got upset and asked why she had stretched her pants. CNA B stated the family complained that she was too rough. She denied abusing the resident or being rough with care. During an interview on 6/02/2025 at 9:22 a.m., the Administrator on 5/29/2025 was the first time she had heard of the incident when surveyor started asking questions. She stated no one had reported it to her prior to this date and an investigation was started on 5/29/2025 after surveyor intervention. She stated after surveyor intervention on 5/29/2025 she called the Resident #7's family about their concerns. She stated Resident #7's family expressed concerns about CNA B. She stated they said CNA B did not seem self-assured with the use of the gait belt. The Administrator stated after the family went back into the room after the toileting, they reported that CNA B told them the next time the resident needed help, they could help her. The Administrator also reported the agency staff wiped the resident hard per Resident #7. The Administrator stated the DON had responded by removing CNA B from caring for the resident. The Administrator stated CNA E got involved because she was the scheduler and the family originally told CNA E. She stated CNA E then told the DON and the DON responded by removing her from the care of the resident. The Administrator stated since learning of the incident on 5/29/2025 she knows CNA E did not report the incident to her, she reported to the DON. She stated the DON indicated CNA E told her CNA B was very rude, mentioned the gait belt and said she was wiped hard. The Administrator stated the DON strictly recalled the RP saying CNA B was rude but does not recall anything else except being upset about the gait belt. The Administrator stated she did not know what she expected the DON to do. She stated that would have depended on what the DON was told. The Administrator stated she thought the DON handled it appropriately and would not have expected it to be reported based on what she was told. The Administrator stated rudeness was a common complaint made of agency staff. She stated to distinguish rudeness from abuse was based on mental anguish. She stated when they hired agency, they did not know their work ethic. She stated agency staff come with an attitude, but it does not mean it crossed the line into abusiveness. The Administrator stated they did have an abuse policy in place which does require a thorough investigation. She stated the staff received abuse training upon hire and annually. She stated they do abuse in-services as issues arise that are specific to the issue at hand. She stated there are keywords such as hard, rough, pain that should be investigated and reported. She stated rough care should be looked at, but she could not say if it was or was not abuse. She stated agency staff, such as CNA B did receive abuse training before she was allowed to work on the floor. Record review of a facility policy, titled Abuse, Neglect, Exploitation, or Misappropriation-Reporting and Investigating last revised September 2022 revealed: All reports of abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Finding of all investigations are documented and reported.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents for 1 of 7 resident (Resident # 7) reviewed for activities of daily living. The facility failed to ensure CNA B utilized a gait belt to transfer Resident #7 while toileting. This failure could place residents at risk for falls, injury and a diminished quality of life. The findings include: Record review of Resident #7's face sheet dated 5/29/2025 revealed a [AGE] year-old female, admitted on [DATE] and readmitted [DATE] with diagnoses which included: noninfective gastroenteritis and colitis (inflammation of the stomach and colon), generalized muscle weakness and urge incontinence. Record review of Resident #7's modification of 5-day admission MDS assessment dated [DATE] revealed a BIMs score of 15 which indicated the resident was cognitively intact. The assessment indicated Resident #7 required maximum assistance with transfers. Record review of Resident #7's Care Plan for ADL self-care last revised on 5/28/2025 revealed the resident required the assistance of one staff member for toileting and transfers. Prior to the revision, her care plan said the same. During an interview on 5/29/2025 at 1:25 p.m. with Resident #7 and her family members, Resident #7 appeared confused to short term memory recall. She was unable to accurately recall what she had for lunch that day. She stated staff checked on her several times during the day and at night and she felt safe in the building with no current concerns. Resident #7's family members #1 and #2 stated they had concerns about CNA B (an agency staff member) who refused to use a gait belt for a transfer. Family member #2 stated agency CNA B sometime last week on an unknown date during the daytime shift assisted Resident #7 to the bathroom. Family member #2 stated the family stepped out into the hallway to give Resident #7 some privacy while the staff took the resident to the toilet. She stated when she was finished toileting Resident #7's face was beet red, she was upset and stated CNA B pushed her down onto the toilet. Family member #2 stated they could tell and felt like something had occurred because Resident #7 was upset. She stated Resident #7 was unable to say exactly what had occurred. During an interview on 5/29/2025 at 2:25 p.m., CNA E who identified herself as the facility scheduler, stated on an unknown date, last week on day shift, Resident #7's family had approached her and stated agency CNA B had taken Resident #7 to the bathroom. They stated there was a gait belt in the room, but CNA B stated she did not use one and they stepped out. CNA E stated the family said when they went back in the resident had stated CNA B was very rough with her. CNA E stated she asked Resident #7 what had happened. She stated she was rough with her when she wiped her. CNA E stated she did not say anything else just that she was rough when she wiped. CNA E stated the family reported CNA B told them if they were in the room, they should be helping the resident instead of her. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 6:23 p.m., the DON stated CNA E reported to her the family was upset because CNA B refused a gait belt and was rude. She stated she informed CNA B the family was upset that she did not use a gait belt and was rude. The DON stated CNA B responded by saying it was not necessary to use a gait belt for a one person assist who was able to stand for the commode. The DON stated she told CNA B she should have used a gait belt. During an interview on 5/29/2025 at 7:28 p.m., the DON stated Resident #7 did not have any injuries as a result. The DON stated she told CNA E not to utilize CNA B on the schedule any longer. She stated since the family made a complaint about her refusing to use a gait belt, they just decided not to use her as agency. The DON stated the did not know the agency staff work ethic until they were in the building. She stated some are good and some are bad, and they try to weed out the bad ones. She stated she did not do any training because they just were not going to use any agency person without a good work ethic. The DON stated a gait belt should be utilized for transfers for safety. During an interview on 5/30/2025 at 8:02 a.m. CNA B (agency staff) stated 5/23/2025 was the date the bathroom situation occurred and 5/24/2025 was the day she was sent home. CNA B stated on 5/23/2025 Resident #7 call light was going off and two people in the room (family) told her the resident needed to go to the bathroom. CNA B stated after the resident finished on the toilet, she was helping the resident transfer from the commode to the wheelchair and the resident's foot got stuck and her knee locked. CNA B stated she told Resident #7 to hold onto the rail. She stated she grabbed Resident #7 by the pants, pulled her up by her pants and helped her to pivot to the wheelchair. CNA B stated Resident #1 got upset and asked why she had stretched her pants. CNA B stated the family complained that she was too rough. CNA B stated she was not going to let the lady fall. She stated it was tight quarters and she pulled the pants with the belt loop to get her up and to pivot. She stated she never saw a gait belt in the facility when she worked there and she never asked for one. She denied that the family asked her to use one. She stated they just asked her to assist her to the toilet. CNA B stated Resident #7 leaned forward in her chair and assisted with the transfer. She stated for the transfer from the recliner to the bathroom she put her hand under Resident #7's arm and assisted her to a standing position while the resident did most of the work. She stated it was from the commode to the wheelchair where she got in trouble. She stated she was trained to use a gait belt to do one person transfers. During an interview on 6/02/2025 at 1:41 pm the DON stated they did not have a policy for one person transfers or gait belt transfers.