

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/27/2025
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)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication irregularities reported from the pharmacist were reported to the attending physician and the facility's medical director and director of nursing, and these reports were acted upon for 1 of 4 residents (Resident #4) reviewed for medications. The facility failed to ensure an order discrepancy for Resident #4's medication Pramipexole (a medication for a progressive neurological disorder known as Parkinson's Disease) identified by a report from the pharmacist to the facility on 6/23/2025 was resolved causing Resident #4 to receive dosing of the medication greater than intended for June, July, and August of 2025. This failure could lead to toxic ingestion or unintended side effects of residents' medications. Findings included: Record review of Resident #4's face sheet dated 8/26/2025 reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Parkinson's disease (a progressive neurological disorder that affects movement, balance, and coordination), anxiety disorder, and Alzheimer's Disease (a progressive neurological disorder affecting thinking and reasoning). Record review of Resident #4's quarterly MDS, submitted 8/13/2025, revealed a BIMS score of 14, indicating intact cognition. Section I of the MDS reflected the same diagnoses previously listed. Record review of a progress note dated 8/5/2025 written by the psychiatric NP reflected Resident #4's treatment plan included a total dose of Pramipexole 1.25mg three times a day. Record review of Resident #4's active physician orders revealed the following:Pramipexole 0.25mg tablet, give 1 tablet by mouth 3 times a day. Give with 1mg to equal 1.25mg for Parkinson's (ordered 4/10/2025)Pramipexole 1.5mg tablet, give 1 tablet by mouth 3 times a day for Parkinson's (ordered 5/22/2025)Record review of Resident #4's MAR reflected Resident #4 received both tablets of Pramipexole, totaling 1.75mg, three times a day in June, July, and August of 2025. Record review of Resident #4's medication regimen review from the consulting pharmacist reflected a recommendation dated 6/23/2025 that read as follows:Pramipexole dose - is total dose 1.75mg TID? Please review 0.25mg dose order in PCC (reads to equal 1.25mg). The document included a column titled follow-through that did not contain any additional notation next to the recommendation for Resident #4. In an interview with Resident #4 on 8/25/2025 at 1:55 PM, she reported no concerns with her medication regimen or the care provided to her by the facility. In an observation and interview on 8/26/2025 at 3:13 PM, two blister packs of medication for Resident #4 were noted to contain Pramipexole 1.5mg tabs and Pramipexole 0.25mg tabs. The instructions on the 0.25mg package reflected give with 1mg to equal 1.25mg. MA H stated Resident #4 had been receiving a total dose of 1.75mg of Pramipexole, and she could not remember if or when the dosage had been changed. She was unaware of the instructions on the order and the blister pack to give a total dose of 1.25mg. LVN I stated the order for the Pramipexole had been unchanged since April of 2025, and she was also unaware of the additional instructions to give a total dose of 1.25mg. In an interview with the DON on 8/26/2026 at 3:20 PM, she stated the order for Resident #4's Pramipexole should have reflected a total dosage of 1.75mg, and she was going to change the order. When shown the progress note from the psychiatric NP reflecting an intended dosage of 1.25mg of Pramipexole, the DON stated she would (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 455628	Facility ID: 455628 If continuation sheet Page 1 of 14

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contact Resident #4's MD to clarify the order prior to changing it. She was unsure why she had not responded to the communication note dated 6/23/2025 from the pharmacist. She said she typically reviews them every month and communicates with the providers in order to correct them timely. In a subsequent interview with the DON and the MD on 8/26/2025 at 3:50 PM, they reported Resident #4's intended dosage of Pramipexole was 1.5mg total. The MD stated the medication was being managed by Resident #4's neurologist, and he had failed to discontinue the Pramipexole order for 0.25mg in May of 2025. He stated the DON and nursing staff were not at fault because they were not aware of the change in dosage that was communicated to him by the neurologist. He stated he had no clinical concerns regarding the incorrect dosage received by Resident #4 since May. The DON stated she was unsure why the recommendation from the pharmacist had not been answered when the document was received on 6/23/2025, as she reviews the recommendations monthly with the MD to ensure all recommendations are addressed. She stated the order for Resident #4's had been corrected to reflect 1.5mg three times a day. In an interview with the pharmacist on 8/27/2025 at 2:40 PM, she stated she had sent the facility documentation requesting clarification of Resident #4's dosage of Pramipexole on 6/23/2025 but had not received a response. She reported no clinical concerns from Resident #4 receiving a total dosage of 1.75mg three times a day. She stated her concern was the accuracy of the dosage. Record review of the facility policy titled Administering Medications (revised April 2019) reflected the following: 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Record review of the facility policy titled Pharmacy Services (undated) reflected the following: Facility procedures should address how and when the need for a consultation will be communicated, how the medication review will be handled if the pharmacist is off-site, how the results or report of their findings will be communicated to the physician, expectations for the physician's response and follow up, and how and where this information will be documented.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents are free from unnecessary drugs for 1 of 4 (Resident #4) residents reviewed for unnecessary medications. The facility failed to ensure Resident #4 received the correct dosage of Pramipexole (a medication used to treat the neurological degenerative disorder known as Parkinson's Disease) in June, July, and August of 2025. This failure could result in accidental overdose or unintended effects of a resident's medication. Findings included: Record review of Resident #4's face sheet dated 8/26/2025 reflected an [AGE] year-old female admitted to the facility on [DATE]. Relevant diagnoses included Parkinson's disease, anxiety disorder, and Alzheimer's Disease (a progressive neurological disorder affecting thinking and reasoning). Record review of Resident #4's quarterly MDS, submitted 8/13/2025, revealed a BIMS score of 14, indicating intact cognition. Section I of the MDS reflected the same diagnoses previously listed. Record review of Resident #4's active physician orders revealed the following:Pramipexole 0.25mg tablet, give 1 tablet by mouth 3 times a day. Give with 1mg to equal 1.25mg for Parkinson's (ordered 4/10/2025)Pramipexole 1.5mg tablet, give 1 tablet by mouth 3 times a day for Parkinson's (ordered 5/22/2025)Record review of Resident #4's MAR reflected Resident #4 received both doses of Pramipexole, totaling 1.75mg, three times a day in June, July, and August of 2025. Record review of Resident #4's medication regimen review from the consulting pharmacist reflected a recommendation dated 6/23/2025 that read as follows:Pramipexole dose - is total dose 1.75mg TID? Please review 0.25mg dose order in PCC (reads to equal 1.25mg). The document included a column titled follow-through that did not contain any additional notation next to the recommendation for Resident #4. Record review of a progress note dated 8/5/2025 written by the psychiatric NP reflected Resident #4's treatment plan included a total dose of Pramipexole 1.25mg three times a day. In an interview with Resident #4 on 8/25/2025 at 1:55 PM, she reported no concerns with her medication regimen or the care provided to her by the facility. In an observation and interview on 8/26/2025 at 3:13 PM, two blister packs of medication for Resident #4 were noted to contain Pramipexole 1.5mg tabs and Pramipexole 0.25mg tabs. The instructions on the 0.25mg package reflected give with 1mg to equal 1.25mg. MA H stated Resident #4 had been receiving a total dose of 1.75mg of Pramipexole, and she could not remember if or when the dosage had been changed. She was unaware of the instructions on the order and the blister pack to give a total dose of 1.25mg. LVN I stated the order for the Pramipexole had been unchanged since April of 2025, and she was also unaware of the additional instructions to give a total dose of 1.25mg. In an interview with the DON on 8/26/2026 at 3:20 PM, she stated the order for Resident #4's Pramipexole should have reflected a total dosage of 1.75mg, and she was going to change the order. When shown the progress note from the psychiatric NP reflecting an intended dosage of 1.25mg of Pramipexole, the DON stated she would contact Resident #4's MD to clarify the order prior to changing it. In a subsequent interview with the DON and the MD on 8/26/2025 at 3:50 PM, they reported Resident #4's intended dosage of Pramipexole was 1.5mg total. The MD stated the medication was being managed by Resident #4's neurologist, and he had failed to discontinue the Pramipexole order for 0.25mg in May of 2025. He stated the DON and nursing staff were not at fault because they were not aware of the change in dosage that was communicated to him by the neurologist. He stated he had no clinical concerns regarding the incorrect dosage received by Resident #4 since May. The DON stated she was unsure why the recommendation from the pharmacist had not been answered when the document was received on 6/23/2025, as she reviews the recommendations monthly with the MD to ensure all recommendations are addressed. She stated the order for Resident #4's had been corrected to reflect 1.5mg three times a day. In an interview with the pharmacist on 8/27/2025 at 2:40 PM, she stated she had sent the facility documentation requesting clarification of Resident #4's dosage of Pramipexole on 6/23/2025 but had not received a response. She reported no clinical concerns from Resident #4 (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving a total dosage of 1.75mg three times a day. She stated her concern was the accuracy of the dosage. Record review of the facility policy titled Administering Medications (revised April 2019) reflected the following: 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Record review of the facility policy titled Pharmacy Services (undated) reflected the following: Facility procedures should address how and when the need for a consultation will be communicated, how the medication review will be handled if the pharmacist is off-site, how the results or report of their findings will be communicated to the physician, expectations for the physician's response and follow up, and how and where this information will be documented.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food for 1 of 1 kitchen in accordance with professional standards for food service safety. 1. The facility failed to ensure 08/27/25 fruit and tossed salad had a temperature of less than 41 degrees prior to service. 2. The facility failed to ensure [NAME] G put parsley on 08/27/25 lunch with food tongs instead of using unsanitary gloves. These failures could place residents at risk for food borne illness. The findings included: Interview and observation on 08/27/25 at 11:47 AM, [NAME] F took the temperature of the tossed salad, and it was 47 degrees F. She took the temperature of the fruit, and it was 44 degrees F. [NAME] F and the kitchen staff were about to use these foods and plate the lunch trays. Interview on 08/27/25 at 11:55 AM, the CDM revealed this tossed salad and fruit were not at the proper temperatures and the kitchen staff needed to cool these foods down before meal service. She revealed these food items needed to be below 41 degrees Fahrenheit. Interview and observation on 08/27/25 at 12:06 PM revealed [NAME] G was putting parsley on residents' lunch meals with his gloved hands that he was also using to touch residents' plates and utensils on the meal tray. The CDM revealed that [NAME] G should be using tongs to put the parsley on top of residents' food Interview on 08/27/25 at 02:58 PM, the CDM revealed [NAME] G knew it was important to use tongs for parsley due to cross contamination. She revealed temperatures were very important to ensure were in recommended ranges (did not mention any other reason why). She revealed she had trained kitchen staff on proper temperatures of foods and how to properly serve food. She revealed she oversaw this, and kitchen staff knew this information already. Interview on 08/27/25 on 03:04 PM, [NAME] F (Cook G was unavailable) revealed if foods were not to temperature they would have to check the food temperature again, and then have a plan of action if they were not at the proper temperature. She revealed this was important, so they were safe to eat for the residents. She revealed they should have used tongs to touch the parsley because [NAME] G was touching everything with the same hands that he was touching the parsley. She further revealed this would help avoid cross contamination. Record Review of facility's policy Food safety, undated, reflected Hands must be washed before putting on gloves and after removing gloves as well as between tasks, between handling raw meats and ready to eat foods and between handling soiled and clean dishes, etc. Record Review of facility's policy Food temperatures, undated, reflected 2. Cold foods should be maintained at a maximum of 41 degrees F.		

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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 observation, interviews, and record reviews the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 8 residents (Resident #61) observed for resident rights. The facility failed to ensure Resident #61 was allowed to eat her dinner meal on her food tray when she requested because she wanted to reduce mess in her area on the dining table. These failures could place residents at risk of not being treated with dignity and respect. Findings included: Record review of Resident #61's admission record, dated 08/27/25, reflected Resident #61 was a [AGE] year-old female initially admitted on [DATE] with diagnoses to include dementia (the loss of cognitive functioning), cognitive communication deficit, need for assistance with personal care, and lack of coordination. Record review of Resident #61's quarterly MDS assessment, dated 07/28/25, reflected Resident #61 had a BIMS score of 10 out of 15, indicating moderate cognitive impairment. It further reflected Resident #61 needed setup or clean-up assistance for eating ADL. Record review of Resident #61's care plan, last reviewed 08/17/25, reflected a focus of The resident has an ADL self-care performance deficit r/t impaired balance, initiated on 02/25/25, with interventions to include EATING: The resident is able to: feed herself with set up assist by 1 person, dated 02/25/25. Observation on 08/26/2025 at 5:35 PM revealed Resident #61 said multiple times that she wanted her dinner to remain on her dinner tray so that there would not be a mess on the table while she ate her dinner. LVN C and CNA E told Resident #61 that they would clean up after her and not to worry. Resident #61 still requested to have her dinner left on her meal tray. Interview on 08/26/2025 at 5:40 PM revealed Resident #61 wanted to leave her dinner meal on her tray because she did not want to make a mess in her area, on the dining table. Resident #45 and Resident #62 were sitting at the same table with Resident #61 and revealed they were okay that Resident #61 had her dinner meal on her tray while she ate, and that Resident #61 preferred her dinner meal stay on her tray while she ate. Interview on 08/26/25 at 05:45 PM, LVN C revealed Resident #61 wanted her dinner on her meal tray and should be able to have her food on the tray if she wanted to because it was her right. LVN C revealed Resident #61 wanted her dinner meal on her meal tray so she did not make a mess, however, they told Resident #61 they would clean up after her. Interview on 08/27/2025 01:05 PM, CNA E revealed she did take Resident #61's 08/26/25 dinner meal off her meal tray because Resident #61 said it was okay. CNA E revealed if Resident #61 wanted her dinner meal left on her meal tray to eat for dinner, she would have left it on her tray. CNA E said they will follow what residents want because it's their right to get what they request. Record review of facility's policy Resident Rights, undated, reflected 1. The resident has the right to exercise his/her rights as a resident of the facility.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to ensure residents had the right to be informed of, and participate in, their treatments, for 1 of 8 residents (Resident #107) reviewed for antipsychotic medication administration. Resident #107 was prescribed and received the antipsychotic medication Perphenazine for schizophrenia without evidence in her medical record of the state consent form 3713. The medication dose and frequency were not included in the consent form. The deficient practices could place residents at risk for side effects for which they did not consent. The findings included: Record review of Resident #107's admission record, dated 08/27/25, reflected Resident #107 was a [AGE] year-old female initially admitted on [DATE] and re-admitted [DATE] with diagnoses to include schizophrenia (mental health condition that affects how people think, feel, and behave). Record review of Resident #107's quarterly MDS assessment, dated 08/20/25, reflected Resident #107 had a BIMS score of 15 out of 15, indicating intact cognition. It further reflected Resident #107 sometimes felt lonely or isolated around others. Record review of Resident #107's Order Summary Report, dated 08/26/25, reflected Perphenazine Oral Tablet 4 MG Give 1 tablet by mouth one time a day for schizophrenia and Perphenazine Oral Tablet 4 MG Give 3 tablet by mouth at bedtime for schizophrenia Record review of Resident #107's Psychoactive Medication Consent (not the 3613 state consent form), dated 06/16/25, reflected Resident #107 consented to take Perphenazine (no dosage or frequency noted) on 06/16/25. Record review of Resident #107's care plan reflected a problem The resident is at risk for adverse reaction r/t POLYPHARMACY (simultaneous use of multiple medications), dated 08/06/25, with interventions Discuss with resident and family the number and type of medications resident is taking and the potential for drug interactions and side effects from over medication, initiated 08/05/25. Interview on 08/27/25 at 12:54 PM, ADON B revealed Psychoactive Medication Consent should be filled out prior to a resident taking a psychoactive medication and when a psychoactive medication was changed. She revealed when she started working in this facility in July was when she started auditing residents' electronic medical record to include ensuring Psychoactive Medication Consents were done and uploaded for residents. Interview on 08/27/25 at 02:20PM, the DON revealed Resident #107 started taking Perphenazine at the end of May. She revealed she was going to look for the 3613 for Perphenazine that was signed before she started taking it. Interview on 08/27/25 at 02:28 PM, DON and ADON B revealed they should have had Perphenazine 3613 signed before resident started taking this medication. The DON revealed it was important to have this form signed because sometimes residents did not want to take medications. ADON B revealed at this time, she oversaw ensuring 3613 forms were signed. Interview on 08/27/25 at 02:56 PM, Resident #107 revealed she was okay with every medication she took. She further revealed she had given consent for every medication she took and there have been no concerns about her medications. Record review of facility's policy Resident Rights, undated, reflected 26. The resident has the right to be fully informed, in advance, about the care and treatment and of any changes in the care or treatment that may affect the resident's well-being.		

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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 observations, interviews, and records reviewed, the facility failed to ensure the resident environment was free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents for 1 of 8 residents (#51) whose care was reviewed for smoking. The facility failed to provide effective monitoring and interventions to prevent Resident #51's unsupervised smoking. This deficient practice could affect resident's safety by smoking unsupervised and residents storing their smoking materials in their rooms and on their person instead of a central lock box which could lead to an unsafe smoking environment. The findings included: Review of Resident #51's face sheet dated 8/26/2025 revealed he was admitted into the facility on 1/04/2023 with diagnoses including cerebral infarction (brain stroke), ataxic gait (abnormal walking pattern), and transient cerebral ischemic attack (mini-stroke). Review of Resident #51's quarterly MDS dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment. Review of Resident #51's care plan dated 08/05/2025 revealed Resident #51 revealed resident is, a smoker with supervision and that resident is at risk for smoking related injury related to resident is a smoker he keeps buying and hiding cigarettes and lighters and will not comply with supervised smoking times. Observation on 8/25/2025 at 11:53 a.m., Resident #51 was observed smoking in the smoking area alone. Observation on 8/26/2025 at 9:47 a.m., Resident #51 was observed smoking in the smoking area alone. Interview on 8/26/2025 at 9:49 a.m., with Resident #51, resident stated he smokes when wanted due to keeping smoking paraphernalia on his person. Interview on 8/26/2025 at 1:36 pm. with LVN D regarding residents who smoke, he stated that all residents who smoke are supposed to be supervised when smoking. He stated that smoking assessments are completed by nursing either quarterly or when it is system generated. Interview on 8/26/2025 at 2:03 pm, with DON, she stated residents who smoke are supposed to be supervised. She stated smoking paraphernalia are locked and kept at the nurse's station. She stated smoking assessments are completed quarterly or when system generated, and they are completed by nursing. Interview on 8/27/2025 at 11:15 am, with Administrator, she stated all residents who smoke are supposed to be supervised. She stated that assessments are completed by nursing. She stated residents are not supposed to have any smoking paraphernalia on their person, it is supposed to be kept locked. Interview on 8/27/2025 at 5:13 pm, with CNA R, she stated smoking paraphernalia are locked and residents who smoke are supposed to be supervised. She stated there is no assigned staff member for smoke times. Interview on 8/27/2025 at 5:20 pm, with Med Aide L, she stated that smoke times are posted at the nurse's station and that residents who smoke are supposed to be supervised. She also stated that there is no assigned staff member at smoke times. Review of [NAME] Healthcare, titled Policy: Smoking - Permitted with Limitations, revealed The facility has a responsibility to oversee their use and provide supervision to maintain an accident-free environment. Furthermore, the policy stated, Matches, lighters, e-pens, etc. will not be accessible to residents that need supervision and/or assistance with smoking.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 8 residents (Resident #88) reviewed for pharmacy services. Nurse A failed to administer Resident #88's medications in a timely manner from 08/22/25 to 08/24/25 (medications to include Duloxetine HCl capsule delayed release particles 30 MG, dexamethasone Oral Tablet 4 MG, Methadone HCl Oral Tablet 10 MG, Lorazepam Oral tablet 0.5 MG, PHENobarbital Oral Tablet 15 MG). This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. Findings included:Record review of Resident #88's admission record, dated 08/26/25, reflected Resident #88 was an [AGE] year-old female admitted on [DATE] with diagnoses to include major depressive disorder. Record review of Resident #88's admission MDS assessment, dated 08/18/25, reflected Resident #88 had a BIMS score of 15 out of 15, indicating intact cognition. Record review of Resident #88's Order Summary Report, dated 08/25/25 and administered by Nurse A, reflected DULoxetine HCl capsule delayed release particles 30 MG Give 1 capsule by mouth in the morning for depression, dexamethasone Oral Tablet 4 MG give 1 tablet by mouth one time a day, Methadone HCl Oral Tablet 10 MG Give 3 tablet by mouth three times a day for pain, Lorazepam Oral tablet 0.5 MG Give 1 tablet by mouth three times a day for Anxiety, PHENobarbital Oral Tablet 15 MG Give 15 mg by mouth three times a day for Pain 1 tab TID Record review of Resident #88's Medication Admin Audit Report for 08/22/25, dated 08/26/25 and administered by Nurse A, reflected DULoxetine HCl capsule delayed release particles 30 MG Give 1 capsule by mouth in the morning for depression, dexamethasone Oral Tablet 4 MG give 1 tablet by mouth one time a day and was administered on 08/22/25 at 10:19 AM when the scheduled time was 08/22/25 at 08:00 AM. Lorazepam Oral tablet 0.5 MG Give 1 tablet by mouth three times a day for Anxiety and Methadone HCl Oral Tablet 10 MG Give 3 tablet by mouth three times a day for pain was administered on 08/22/25 at 10:18 AM when the scheduled time was 08/22/25 at 08:00 AM. PHENobarbital Oral Tablet 15 MG Give 15 mg by mouth three times a day for Pain 1 tab TID was administered on 08/22/25 at 10:17 AM when the scheduled time was 08/22/25 at 08:00 AM. Record review of Resident #88's Medication Admin Audit Report for 08/23/25, dated 08/26/25 and administered by Nurse A, reflected Lorazepam Oral tablet 0.5 MG Give 1 tablet by mouth three times a day for Anxiety, PHENobarbital Oral Tablet 15 MG Give 15 mg by mouth three times a day for Pain 1 tab TID and dexamethasone Oral Tablet 4 MG give 1 tablet by mouth one time a day and Methadone HCl Oral Tablet 10 MG Give 3 tablet by mouth three times a day for pain DULoxetine HCl capsule delayed release particles 30 MG Give 1 capsule by mouth in the morning for depression, was administered 08/23/25 at 01:32 PM when the scheduled time was 08:00 AM, Record review of Resident #88's Medication Admin Audit Report for 08/24/25, dated 08/26/25 and administered by Nurse A, reflected Lorazepam Oral tablet 0.5 MG Give 1 tablet by mouth three times a day for Anxiety, PHENobarbital Oral Tablet 15 MG Give 15 mg by mouth three times a day for Pain 1 tab TID and Methadone HCl Oral Tablet 10 MG Give 3 tablet by mouth three times a day for pain was administered on 08/24/25 at 09:48 AM when the scheduled time was 08:00 AM dexamethasone Oral Tablet 4 MG give 1 tablet by mouth one time a day was administered on 08/24/25 at 09:51 AM when the scheduled time was 08:00 AM and DULoxetine HCl capsule delayed release particles 30 MG Give 1 capsule by mouth in the morning for depression, was administered on 08/24/25 at 09:50 AM when the scheduled time was 08:00 AM Interview and observation on 08/26/25 at 8:41 AM, Resident #88 was crying and revealed she had not received her medications on time, and it affected her mental health. Interview on 08/27/25 at 02:13 PM, Nurse A revealed she thought she did work 08/22 to 08/24 and was late giving out medications but gave no reason why she administered medications late. She revealed it was (continued on next page)		

Department of Health & Human Services
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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 08/27/2025
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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to administer on time because it is the way the doctor prescribed it and to manage pain and their health managed. Interview on 08/27/25 at 03:14 PM, the DON revealed it was important to administer medications on a timely basis because it took time for medications take effect, like pain and psychiatric medications for Resident #88. Record review of facility's policy Pharmacy Services, undated, reflected Strive to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescriber.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record review, the facility failed to follow menus for 2 of 3 resident (Residents #24 and #76) meals reviewed for menus in that: The facility failed to follow the menu for Residents #24 and #76 for 08/25/25 lunch meal service. This failure could place residents who consume food prepared by the facility kitchen at risk of not having their nutritional needs met and/or weight loss. The findings were: Record review of Resident #24's admission record, dated 08/27/25, reflected Resident #24 was an [AGE] year-old male initially admitted on [DATE] with diagnoses to include dementia (the loss of cognitive functioning), muscle wasting and atrophy, vitamin B12 deficiency, and vitamin D deficiency. Record review of Resident #24's quarterly MDS assessment, dated 08/17/25, reflected Resident #24 had a BIMS score of 06 out of 15, indicating severe cognitive impairment. Record review of Resident #24's Order Summary Report, dated 08/27/2025, reflected a diet order of Regular diet Mechanical Soft texture, Thin consistency, with a start date of 05/20/2024. Record review of Resident #24's care plan, last reviewed 08/16/25, reflected a problem of My dietary instructions are: regular diet, mechanical soft texture, thin consistency, initiated on 04/23/24, with interventions to include Dietary to provide diet as ordered per physician Record review of Resident #24's electronic medical record reflected resident had no significant weight loss in the last 6 months. Record review of Resident #76's admission record, dated 08/27/25, reflected Resident #76 was an [AGE] year-old female initially admitted on [DATE] with diagnoses to include cognitive communication deficit, dysphagia (difficulty swallowing), and anxiety disorder. Record review of Resident #76's quarterly MDS assessment, dated 08/07/25, reflected Resident #76 had a BIMS score of 04 out of 15, indicating severe cognitive impairment. Record review of Resident #76's Order Summary Report, dated 08/27/2025, reflected a diet order of Regular diet Regular texture, Thin consistency ., with a start date of 05/16/2024. Record review of Resident #76's care plan, last reviewed 08/16/25, reflected a problem of My dietary instructions are: NAS Regular diet, regular texture, thin consistency, revised 05/29/25, with interventions to include Controlled Carbohydrate (CCHO) diet, REGULAR, THIN consistency Record review of Resident #76's electronic medical record reflected resident had no significant weight loss in the last 6 months. Record review of Week 1 menu, undated, reflected Frosted carrot cake was offered to diabetic residents and residents on a mechanical soft diet. Interview and observation on 08/25/2025 at 12:28 PM, Resident #24 awas not served carrot cake like other residents surrounding them. They revealed they wanted carrot cake and did not know why they were not served carrot cake. Resident #76 added that she also did not receive carrot cake and would like to receive carrot cake. Interview and observation on 08/25/2025 at 12:30 PM, the CDM happened to walk by and asked what was going on. She mentioned the Resident #24 could not get carrot cake because they were served a mechanical soft diet. The CDM further revealed Resident #76 could not be served carrot cake because she was on a diabetic diet. After this occurred, the CDM walked around the dining room to ensure the other residents' lunch meal included carrot cake. Interview on 08/26/25 at 6:32 PM, the CDM revealed the carrot cake was the same carrot cake that was on the menus and menus should be followed. She revealed the kitchen did not have bread pudding, which was the original dessert for today, so they had to substitute for carrot cake. She revealed substitution log was filled out and approved. The CDM revealed she originally thought these diets did not include carrot cake but realized they did include carrot cake so after meal service in the dining room, she ensured all other residents in the facility received carrot (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cake per their diet. Record review of facility's policy Menus, undated, reflected Menus must- be followed.		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to follow their own established smoking policy for 1 of 8 residents (Resident #51) reviewed for smoking in that:Resident #51 was observed smoking unsupervised in the smoking area and stating he keeps the smoking paraphernalia on his person. This deficient practice could place smoking residents at risk for injury while smoking unsupervised.The findings were: Review of Resident #51's face sheet dated 8/26/2025 revealed he was admitted into the facility on 1/04/2023 with diagnoses including cerebral infarction (brain stroke), ataxic gait (abnormal walking pattern), and transient cerebral ischemic attack (mini-stroke) .Review of Resident #51's quarterly MDS dated [DATE], revealed a BIMS score of 10, which indicated moderate cognitive impairment. Review of Resident #51's care plan dated 08/05/2025 revealed Resident #51 revealed resident is, a smoker with supervision and resident will adhere to the tobacco/smoking policies of the facility.Observation on 8/25/2025 at 11:53 a.m., Resident #51 was observed smoking in the smoking area unsupervised. Observation on 8/26/2025 at 9:47 a.m., Resident #51 was observed smoking in the smoking area unsupervised. Interview on 8/26/2025 at 9:49 a.m., with Resident #51, resident stated he smokes when he wanted due to keeping smoking paraphernalia on his person or in his room. Interview on 8/26/2025 at 1:36 pm. with LVN D regarding residents who smoke, he stated that all residents who smoke are supposed to be supervised when smoking. Interview on 8/26/2025 at 2:03 pm, with DON, she stated resident who smoke are supposed to be supervised. She stated smoking paraphernalia are locked and kept at the nurse's station. Interview on 8/27/2025 at 11:15 am, with Administrator, she stated all residents who smoke are supposed to be supervised. She stated residents are not supposed to have any smoking paraphernalia on their person, it is supposed to be kept locked.Interview on 8/27/2025 at 5:13 pm, with CNA R, she stated smoking paraphernalia are locked and residents who smoke are supposed to be supervised. She stated there is no assigned staff member for smoke times. Interview on 8/27/2025 at 5:20 pm, with Med Aide L, she stated that smoke times are posted at the nurse's station and that residents who smoke are supposed to be supervised. She also stated that there is no assigned staff member at smoke times. Review of [NAME] Healthcare, titled Policy: Smoking - Permitted with Limitations, revealed The facility has a responsibility to oversee their use and provide supervision to maintain an accident-free environment. Furthermore, the policy stated, Matches, lighters, e-pens, etc. will not be accessible to residents that need supervision and/or assistance with smoking.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have bedrooms that measured 80 square feet per resident in multiple bedrooms for 15 of 99 rooms (Rooms #1-5, 7-9, 12-14, 21, 27, 28, and 46) resident rooms reviewed for square footage. Based on List of measured rooms, Rooms #1-5, 7-9, 12-14, 21, 27-28 and 46 were between 72.4 and 76.4 square feet per resident per bedroom. This failure could negatively affect the quality of life for the residents living in these rooms by restricting the amount of resident care equipment and resident's personal effects that could be accommodated in these resident rooms, limiting the resident's ability to move about the room, and decreasing resident's quality of life. The findings were: During the entrance conference with the ADM on 08/25/25 at 09:18 AM, the ADM revealed they had some rooms that did not meet the required square footage. A review of Form 3762 (Room Size Waiver) signed by the Administrator on 08/26/25 revealed resident rooms 1-5, 7-9, 12-14, 21, 27, 28, and 46 were all certified rooms for two beds each and did not meet the justification criteria. Review of the undated List of Rooms meeting any one of the following: Less than the required square footage revealed rooms 1-5, 7-9, 12-14, 21, 27, 28 and 46 were listed. The measurements were as follows: room [ROOM NUMBER]: 152.8 square feet (approximately 76.4 square feet for each resident);room [ROOM NUMBER]: 149.8 square feet (approximately 74.9 square feet for each resident);room [ROOM NUMBER]: 149.2 square feet (approximately 74.6 square feet for each resident);room [ROOM NUMBER]: 148.2 square feet (approximately 74.1 square feet for each resident);room [ROOM NUMBER]: 148.2 square feet (approximately 74.1 square feet for each resident);room [ROOM NUMBER]: 148.5 square feet (approximately 74.25 square feet for each resident);room [ROOM NUMBER]: 147.9 square feet (approximately 73.95 square feet for each resident);room [ROOM NUMBER]: 148.4 square feet (approximately 74.2 square feet for each resident);room [ROOM NUMBER]: 149.2 square feet (approximately 74.6 square feet for each resident);room [ROOM NUMBER]: 149.4 square feet (approximately 74.7 square feet for each resident);room [ROOM NUMBER]: 147.1 square feet (approximately 73.55 square feet for each resident);room [ROOM NUMBER]: 144.8 square feet (approximately 72.4 square feet for each resident);room [ROOM NUMBER]: 150.2 square feet (approximately 75.1 square feet for each resident);room [ROOM NUMBER]: 145.3 square feet (approximately 72.65 square feet for each resident); androom [ROOM NUMBER]: 149.6 square feet (approximately 74.8 square feet for each resident).		