STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey started on 03/06/17 and completed on 03/08/17, the sample included three (3) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 157		4/13/17

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

Electronically Signed | 03/29/2017

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F 157	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, the facility failed to ensure notification of a family member for 1 of 1 sampled resident (Resident #4) who accidentally consumed finger nail polish remover. Failure to notify a residents' family member regarding the resident accidentally swallowing finger nail polish remover limited the family members ability to make an informed decision regarding the resident's care and may affect the residents quality of life. Findings included: Review of the facility policy titled "Accident and Incident Report" occurred on 03/08/17. This policy, dated September 1999, stated, " b. Resident Accident/Near Miss Report . . . 2. Charge nurse will notify physician and family as	F 157	F157 1. Res #4 and/or residents representative will be notified when there is an incident involving the resident and has the potential for requiring physician intervention. Resident s #4 POA was notified of incident on 4/3/17 per phone call. They will be notified of any future incidents. 2. All residents have the potential to be affected by this deficient practice. 3. Policy was reviewed and updated to ensure family is notified with all incidents. Incident report and Matrix event form updated to include a reminder to call	

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F 157	Continued From page 2 necessary. . . ." Review of Resident #4's medical record occurred on all days of survey. Diagnoses included dementia and Schizoaffective disorder. Review of Resident #4's nursing progress notes identified the following: * 01/25/17 - 10:44 p.m. "Resident approached nurses station and stated she accidentally swallowed a mouthful of non-acetone nail polish remover. C/o [complain of] burning sensation in her mouth and throat. North Dakota Poison Control notified via telephone. Representative stated resident may experience mild irritation of mouth and throat, but did not need to seek emergency attention. Resident is to eat a popsicle or ice cream to soothe irritated tissue. Notified on call MD [Medical Doctor] of incident, MD states it is not necessary for resident to go to ER [Emergency room] at this time. Will monitor for changes." * 01/26/17 - 9:45 a.m. "Resident is feel [sic] OK this AM no c/o upset stomach or throat pain." During an interview on 03/07/17 at 3:52 p.m., a nurse manager (#5) stated staff did not complete an accident and incident report and did not notify Resident #4's family. This nurse stated she expects staff to notify a family member regarding this type of incident.	F 157	residents representative with any events that results in injury or requires notification of physician for intervention. Education will be provided to social services on 4/4/17 and at the nurses meeting on 4/6/17 regarding this policy change of family notification and change in incident and event forms and the importance of notifying family of all incidents. 4. Nurse Management will audit 30% of resident incident reports weekly x4, bi-weekly x2, then monthly x4 from completion date 04/13/2017. Findings will be reported to QAPI nurse, QAPI Committee and at the Quarterly QAPI meeting. 5. 5.Completion Date 04-13-2017	
F 205 SS=C	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the	F 205		4/13/17

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F 205	Continued From page 3 resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide a bed-hold notice upon transfer for 1 of 12 sampled residents (Resident #1) and 1 closed record (Resident #14) transferred for hospitalization. Failure to provide a transferred resident the option of a complete bed hold notice does not allow the resident to make an informed choice regarding their rights.	F 205	F205 1. Resident #1 and/or their family members will be given written notice that specifies the duration of the bed hold policy when the resident is being transferred to a hospital or goes on therapeutic leave. Resident # 14 is a closed case record.	

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F 205	Continued From page 4 Findings include: - Review of Resident #1's medical record occurred on all days of survey. Resident #1 was hospitalized once. The previously used "Notification of Transfer for Hospitalization, Therapeutic Leave & Bed Hold" form, dated 01/20/17, provided for the bed hold notice lacked the choice for the resident or the resident's representative to specify the duration of the bed-hold. - Review of Resident #14's medical record occurred on March 7-8, 2017. Resident #14 was hospitalized twice. The previously used "Notification of Transfer for Hospitalization, Therapeutic Leave & Bed Hold" form, dated 01/05/17, provided for the bed hold notice lacked the choice for the resident or the resident's representative to specify the duration of the bed-hold. The updated "Notice of Transfer for Hospitalization" form, dated 02/17/17, failed to address bed hold requirements. During an interview on the morning of 03/08/17, two administrative nurses (#3 and #4) confirmed the facility did not currently have a bed hold notice for any resident transferred to the hospital.	F 205	2. All Residents transferring to a hospital or going on therapeutic leave have the potential to be affected by this deficient practice. 3. A Notification of Bed Hold Policy Form was reviewed and updated. The facility will notify the resident and/or family member of the duration of bed hold policy with all transfers to hospital and therapeutic leave. Bed Hold Policy form be will be reviewed and educated at the Charge nurse meeting on 04/06/2017 and also reviewed with office staff on 04/06/2017. The Green department notification form will be changed to include a reminder to complete bed hold form and transfer form when resident leaves facility. Charge nurse will complete the notification prior to sending a resident to the hospital or for a therapeutic leave. 4. The business office will audit files of residents which were admitted to the hospital or those who have been on therapeutic leave weekly x4, bi-weekly x2, then monthly x4. Findings will be reported to QAPI nurse, QAPI Committee and at the Quarterly QAPI meeting. 5. Completion Date 04-13-2017	
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals	F 225		4/13/17

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F 225	Continued From page 5 who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving 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, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey	F 225		

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F 225	Continued From page 6 Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to identify and immediately report 2 of 2 potential incidents of neglect (05/23/16 and 10/14/16) involving Resident #13 to the state survey and certification agency and report the results of the investigations within five working days. Failure to identify, report, and thoroughly investigate all potential violations of neglect places all residents at risk of neglect and subsequent injury. Findings include: Review of the facility policy titled "Abuse and Neglect Prohibition" occurred on 03/08/17. This policy, revised December 2016, stated, "'. . . 'Neglect' - is defined as failure to carry out	F 225	F225 1. Res #13 since expired and was identified in a closed record. 2. All residents have the potential to be affected by this deficient practice. 3. The Abuse and Neglect Prohibition Policy was reviewed and education given to all nursing staff at 4/6/17 Nurses Staff Meeting. Education and policy review completed with SSD regarding reportable and suspected abuse case reporting. Any reportable or suspected case of abuse and neglect will be investigated internally by SSD and another appropriate	

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F 225	Continued From page 7 resident services as directed or ordered by the physician or other authorized personnel, failure to give proper attention to residents, or failure to carry out resident services through careless oversight. . . . Allegations of . . . neglect . . . will be thoroughly investigated and documented using established procedures. For Certified Nursing Assistants [CNAs], a report shall be made to the State Department of Health and . . . within five (5) working days of the reporting of the alleged incident. . . ." - Review of Resident #13's medical record occurred on March 7-8, 2017. Diagnoses included Alzheimer's disease, osteopenia, osteoarthritis, and history of falls. The significant change Minimum Data Set (MDS), dated 10/03/16, identified severely impaired cognitive skills, extensive assistance required for transfers, and a history of falls. Resident #13's care plan identified, ". . . transfers stand lift . . . fall risk . . . bed in low position with fall mat beside bed. . . ." A progress note, dated 05/23/16, identified, "R [Resident] was found on the floor by CNA . . . during rounds and his bed was in highest position and his side table was broken, [Resident] said he was dreaming and didn't know what happened, denies pain at this time but had a 2 inch scratch on his r [right] forearm. The wound was cleaned and covered with appropriate dressing. No other injuries noted at this time. . . . Post-fall charting . . . He has a 5cm [centimeter] ST [skin tear] on the posterior R [right]-forearm; Bacitracin and bandage applied daily until healed. . . ."	F 225	administrative staff. Incidents will be reported to ND State Health Department per policy. 4. SSD will audit all alleged violations involving mistreatment, neglect or abuse or misappropriation of property to ensure policy is being followed for reporting and investigation. Audits will be done weekly x4, bi-weekly x2, then monthly x4. Findings will be reported to the QAPI nurse, QAPI Committee and at Quarterly QAPI meeting. 5. Completion Date 04-13-2017	

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F 225	Continued From page 8	F 225		

An event report, dated 05/23/16, identified, ". . . Pt [patient] was found on the floor laying on his right side with pt bed in high position and side table broken. . . ." Other than the notification section, staff left the remainder of the event form blank.

A progress note, dated 10/14/16, identified, "Resident was being transferred with stand up lift when resident side [sic] out and fall to fall [sic]. No injuries or bruising noted. . . . Post fall charting: . . . No new skin lesions were noted brought about by recent fall. . . ."

An event report, dated 10/14/16, identified, ". . . Resident was being transferred with stand up lift when resident side [sic] out and fall to fall [sic]. No injury or bruising noted. . . . Witnessed . . ."

During an interview on 03/08/17 at 4:30 p.m., a managerial nurse (#5) reported staff failed to complete an incident report on the fall that occurred on 05/23/16 (fall from bed; bed in high position). In regards to the fall that occurred on 10/14/16 (fall from stand-lift), the managerial nurse (#5) reported the CNA made the following statement, "I was using the stand lift on him and I had the belt tight as can be and he slid right out of it onto the floor." She (#5) also reported the "CNA received training and was instructed to follow the care plan by management nurses after the fall."

The facility failed to investigate Resident #13's fall from his bed, and conducted a cursory investigation of his fall from the stand lift. These failures placed all residents at risk of potential neglect when it could not be determined if:

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F 225	Continued From page 9 * direct care staff followed Resident #13's care plan by placing his bed in the lowest position, * direct care staff utilized the stand lift per the manufacturer's guidelines, * nursing/physical therapy staff assessed/determined the appropriate sized sling for Resident #13, * maintenance assessed/determined the stand lift was in proper working condition, * nursing staff thoroughly completed event forms immediately following each incident. The facility also failed to immediately report the incidents to the state survey and certification agency and failed to report the results of their investigations within five working days.	F 225		
F 278 SS=F	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual	F 278		4/13/17

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F 278	Continued From page 10 who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.14), the facility failed to use the entire required days of observation when completing Minimum Data Set (MDS) items on 11 of 12 sampled residents (Resident #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, and #12). Failure to include all the days of the look back period when completing the MDS has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3, page A-31 stated, ". . . As the last day of the look-back period, the ARD [Assessment Reference Date] serves as the reference point for determining the care and services captured on the MDS assessment . . . For example, the MDS item with	F 278	F 278 1. Resident # 1, #2, #4, #5, #6, #7, #8, #9, #10, #11, and #12 section K MDS will be completed after the set ARD. 2. All resident□s in the facility requiring any MDS completion have the potential to be affected. 3. Education has been completed to all staff who facilitate and complete the MDS on 3/28/17 regarding ARD dates and completion of MDS after the ARD with the complete look back period reviewed. 4. The MDS Coordinator or nurse manager will audit all completion dates of every sections of the MDS of 50% of scheduled MDS□s weekly x4, then 50% of scheduled MDS monthly x3, 50% of bi-monthly scheduled MDS x2. All	

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F 278	Continued From page 11 a 7-day look-back period ending on and including the ARD which is the 7th day of this look-back period . . ." Therefore, the earliest you can code items with a look-back period and attest to the accuracy in Z0400 would be the day after the ARD. Each person completing a section of the MDS is required to sign the attestation statement (Z0400) as identified on page Z-6 that reads, "I certify that the accompanying information accurately reflects resident assessment information for this resident . . . " Page Z-7 stated, ". . . All staff who completed . . . and the date completed . . ." Legally, item Z0400 is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. - Review of Resident #1's medical record occurred on all days of survey. A quarterly MDS with an ARD of 01/30/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 01/30/17. - Review of Resident #2's medical record occurred on all days of the survey. A quarterly MDS with an ARD of 11/30/16 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 11/30/16. - Review of Resident #4's medical record occurred on all days of survey. A quarterly MDS with an ARD of 02/11/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 02/07/17.	F 278	findings will be reported to QAPI nurse, QAPI committee and quarterly QAPI meeting. 5. Completion date 4/13/17	

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F 278	Continued From page 12 - Review of Resident #5's medical record occurred on all days of the survey. A quarterly MDS with an ARD of 02/08/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 02/07/17. - Review of Resident #6's medical record occurred on all days of the survey. A quarterly MDS with an ARD of 01/24/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 01/24/17. - Review of Resident #7's medical record occurred on all days of survey. An annual MDS with an ARD of 02/10/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 02/07/17. - Review of Resident #8's medical record occurred on all days of survey. A quarterly MDS with an ARD of 02/06/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 02/06/17. - Review of Resident #9's medical record occurred on 03/08/17. A quarterly MDS with an ARD of 01/20/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 01/17/17. - Review of Resident #10's medical record occurred on 03/08/17. An annual MDS with an ARD of 12/05/16 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 12/05/16.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

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F 278	Continued From page 13 - Review of Resident #11's medical record occurred on 03/08/17. A quarterly MDS with an ARD of 12/20/16 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 12/20/16. - Review of Resident #12's medical record occurred on 03/08/17. A quarterly MDS with an ARD of 02/25/17 identified the following: *Sections K0100, K0510, and K0710 completed with a Z0400 date of 02/24/17.	F 278		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		4/13/17

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F 280	Continued From page 14 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 280		

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F 280	Continued From page 15 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and resident/staff interviews, the facility failed to review and revise the comprehensive care plan to reflect the residents' status for 4 of 12 sampled residents (Resident #2, #4, #6, and #11). Failure to review and revise the care plan limited staff's ability to communicate care needs and ensure continuity of care for each resident. Findings include: Review of the facility policy titled "Care Plan" occurred on 03/08/17. This policy, dated October 1999, stated, ". . . 4. Care plans will be updated and/or reviewed with any quarterly, annual or significant change MDS, or more frequently if needed. 5. Care Plans are to be updated as problems/needs change or new problems/needs arise. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses	F 280	F 280 1. Resident #2, #4, #6, and #11 care plans have been reviewed and all information is now up to date and accurate. 2. All resident□s in the facility have the potential to be affected. 3. All care plan interventions will be reviewed quarterly and prn with changes and updated as indicated. A care plan change form has been created and given to all departments. Education will be given at department head meeting on 4/4/17 and the nurses meeting on 4/6/17 regarding care plan monitoring and updating the care plan. Every resident who has an order for scheduled or prn pain medication will have a pain care plan added.	

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F 280	Continued From page 16 included hearing loss. The current care plan stated, ". . . Able to make simple day to day decisions but requires assistance with major decision. . . . [Resident #2] has difficulty understanding others at times due to his hearing loss. [Resident #2] also has occasional confussion [sic] at times. . . ." The progress notes identified the following: * 01/12/17, "Resident was exiting Carus Court and stated to this nurse, 'Those black bastards were supposed to refill my oxygen tank and they didn't. You can't trust anyone of those black ones, I swear!' Informed resident his remark was disrespectful and inappropriate. Asked resident not to speak in that way in public. Resident replied, 'I can say whatever the hell I want.' Difficult to redirect . . ." * 02/04/17, "Resident stated to nurse, 'I've been out of oxygen for about 30 minutes. I asked one of those god damn niggers to fill it for me, he smiled and left the tank here. Those niggers aren't any good for anything. I don't understand why you hire them!' Informed resident his language was inappropriate and offensive and asked him not to use that type of language. Resident states, 'I don't care who it offends. It makes me damn mad that I can't get oxygen when I need it!' Difficult to redirect. Daughter . . . here, informed her of resident behavior. [Daughter] states she would talk to her Dad about his language. . . ." Observation showed the following: * 03/07/17 at 7:00 a.m., A black certified nursing assistant (CNA) (#8) provided Resident #2's toileting cares, prior to assisting him to the whirlpool room located on a different unit.	F 280	4. The MDS coordinator or nurse manager will audit 30% of care plans weekly x4, bi-weekly x2, then monthly x4. All findings will be reported to QAPI nurse, QAPI committee and quarterly QAPI meeting. 5. Completion date 4/13/17.	

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F 280	Continued From page 17 Resident #2 made the following comments as they walked through the halls, "Those blacks are lazy. They're terrible. You can't understand them. They don't do what they're supposed to do." * 03/08/17 at 9:40 a.m., Resident #2 sat in his recliner watching television. When asked questions concerning his morning cares, he made the following comments, "Those blacks do half [of] what they're supposed to. They're terrible. That one this morning is not worth a damn. I gave [him] hell, so there are some [washcloths in the bathroom] now." The current care plan failed to identify the Resident #2's racist belief system or address his subsequent behaviors, placing both Resident #2 and the black staff members at risk of harm and/or allegations of abuse/neglect. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included left bunion surgery (02/02/17). Review of the resident's as needed (PRN) pain medications identified the following: * oxycodone-acetaminophin 5-325 milligrams (mg) every four hours PRN for pain - administered almost daily from February 2 through March 7, 2017. The current care plan failed to address the resident's pain problem including goals and interventions. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included osteoarthritis. Review of the resident's PRN pain medications identified the following: * Morphine 0.25 millimeters sublingual every 1	F 280		

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F 280	Continued From page 18	F 280		

hour PRN for pain - administered on 4 occasions from February 1 through March 7, 2017
* Tylenol 650 mg every 4 hours PRN for pain - administered on 6 occasions from February 1 through March 7, 2017

The current care plan failed to address the resident's pain problem including goals and interventions.

Resident #6's current care plan stated, ". . . TRANSFERS . . . GAIT BELT. . . ."

Observations throughout survey identified CNAs transferred Resident #6 with a mechanical stand lift.

Review of Resident #6's progress notes identified on 10/04/16 a nurse instructed a CNA to use the stand lift due to the resident's increasing weakness.

During an interview on the afternoon of 03/08/17, a nurse manager (#4) agreed the resident now used a stand lift, and the care plan failed to reflect this change.

- Review of Resident #11's medical record occurred on 03/08/17. Diagnoses included osteoporosis, bilateral primary osteoarthritis of hip, pain in right and left hip, and myalgia-(left buttock pain). Current scheduled pain medications included acetaminophen 1000 mg once a day and a PRN hydrocodone-acetaminophen 7.5-325 mg ordered every 4 hours for pain. Staff had administered the hydrocodone-acetaminophen on 20 occasions from February 1 through March

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F 280	Continued From page 19 7, 2017. Resident #11's care plan failed to address the resident's pain problem including goals and interventions.	F 280		
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: MEDICATIONS LEFT AT THE TABLE/BEDSIDE 1. Based on observation, record review, review of professional reference, and staff interview, the facility failed to follow professional standards of care for 2 of 2 sampled residents (Resident #3 and #7) observed with medications left at the dining room table or at their bedside. Failure to ensure staff left medications with only residents assessed by the facility as safe to self administer medications may result in medication errors for Resident #3 and #7 and other residents who, inadvertently, consume the unattended medications. Findings include: Berman, Snyder, and Frandsen, "Kozier & Erb's Fundamentals of Nursing, Concepts, Process, and Practice", 10th ed., Pearson Education, Inc., New Jersey, page 769, stated, "Administering	F 281	F281 1. Resident #3 and #7 will continue to not be able to self-administer medications. Resident #3, #4 and #6 physician□s orders have been reviewed and now reflect current orders/treatments. 2. All resident□s in the facility have the potential to be affected. 3. A nurses meeting will be held on April 6, 2017. Education regarding our self-administration policy and physician□s order will be discussed. 4. Nursing Management will complete a Professional standard audit for self-administration and MD orders on 5 residents weekly x4, bi-weekly x2, then monthly x4. All findings will be reported to	4/13/17

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F 281	Continued From page 20 Medications . . . Do not leave medications at the bedside, . . ." - Review of Resident #7's medical record occurred on all days of survey and identified the resident resided on the special care unit of the facility. Diagnoses included Alzheimer's disease. The annual Minimum Data Set (MDS), dated 02/10/17, identified severe cognitive impairment. The resident's assessment for self administration of medications (SAM), dated 02/10/17, stated "unable to self admin [administer]". Observation on 03/07/17 at 7:27 a.m. showed a nurse (#1) prepared Resident #7's morning medications which included lorazepam (antianxiety), lisinopril (blood pressure), metoprolol (heart function), lasix (diuretic), diltiazem (heart function), pravastatin (cholesterol), sertraline (antidepressant), potassium chloride, Depakote (anticonvulsant), Namenda (anti-Alzheimer's disease), calcium, vitamin C, fish oil, and eye drops. The nurse (#1) placed a cup containing all the medications on the dining room table in front of Resident #7 and watched her consume approximately three pills. The nurse stated, "I make her nervous", and exited the dining room. Observation showed two other residents seated at the table with Resident #7 and eight more residents present in the dining room. At 7:43 a.m., the certified nursing assistant (CNA) (#2) told Resident #7 she still had one pill to take. The resident stated, "I know." During an interview on 03/07/17 at 2:30 p.m., two administrative nurses (#3 and #4) stated they expected staff to stay with Resident #7 until she consumed all of her medications.	F 281	QAPI nurse, QAPI committee and quarterly QAPI meeting. 5. Completion date 4/13/17	

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F 281	Continued From page 21 - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. An Assessment for Self Administration of Medications completed on 01/16/17 identified Resident #3 unable to demonstrate correct administration of medications (including eye drops) and has no desire to self administer medications. Observation on 03/07/17 at 8:20 a.m. and 1:28 p.m. showed a bottle of liquid tears eye drop solution on Resident #3's bedside stand. During an interview on 03/07/17 at 2:00 p.m., two administrative nurses (#3 and #4) stated they were not aware Resident #3 had eye drops in her room. FOLLOWING PHYSICIAN ORDERS 2. Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 3 of 12 residents (Resident #3, #4, and #6) reviewed for following physician orders. Failure to follow physician orders may result in incorrect treatment of residents' conditions. Findings include: Review of the facility policy titled "Medication Administration" occurred on 03/08/17. This policy, dated October 1999, stated, "1. Medication must be administered in accordance	F 281		

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	355092	A. BUILDING _____ B. WING _____	03/08/2017

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F 281	Continued From page 22 with the written orders of the physician. . . ." - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included dysuria (pain with urination), urgency of urination, and upper respiratory infection. The current care plan stated, " . . . Resident is Continent of bladder and bowel . . . Report signs of UTI [urinary tract infection] (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating . . .)" A physician's order dated 01/25/17, stated, "Collect UA [urinary analysis] due to c/o [complains of] urinary freq [frequency] and dysuria. . . ." Resident #3's nursing progress notes stated the following: *01/25/17 - 12:13 p.m. "[Name] FNP [family nurse practitioner] here on rounds and assessed resident and new orders to collect UA . . ." *01/25/17 - 8:04 p.m. "Attempted to obtain UA on resident to assess for UTI d/t [due to] frequency and urgency. Resident states, 'I don't want to pee in a cup.' Will attempt at later time." During an interview on 03/07/17 at 3:52 p.m., a nurse manager (#5) stated staff failed to obtain the UA as ordered by the FNP. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included left bunion surgery (02/02/17). A post surgical physician order dated, 02/02/17, stated, dressings to remain clean, dry, and intact.	F 281		

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 281	Continued From page 23 Resident #4's nursing progress notes stated the following: * 02/02/17 1:19 p.m. "Resident returned from same day surgery with Dr. [name] to have left foot bunion fixed. Received orders to keep dressing clean, dry and intact until seen for follow up on Monday with Dr. [name], if dressing bleeds through reinforcement can be done. Resident to limit activity, no bath nor tub until seen on Monday, resident to wear orth [orthotic] boot when up and around, may leave off when resting and foot elevated. . . ." * 02/03/17 11:11 a.m. "Resident needs constant reminders to rest her left foot, and to elevate. Resident in recliner boot removed, noted dressing had bled through into ace wrap as well. Dressing removed with NS [normal saline] solution, noted bruising to incision site stitches in place, incision site closed, clean, no active drainage noted with dressing change. Gauze and new ace wrap applied, resident tolerated change well, no distress noted." During an interview on the afternoon of 03/07/17, a licensed nurse (#7) stated she called the physician and received an order to do a dressing change and continue with follow up on Monday. Staff failed to document the telephone call to the physician and document the physician's order for a dressing change. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD). A physician order, dated 02/08/17, stated, "02 [oxygen] @ [at] 4L [liters] PER Mask. . . ."	F 281		

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F 281	Continued From page 24 Observation throughout survey identified Resident #6 on 4L 02 per nasal cannula. During an interview on the afternoon of 03/08/17, the managers (#3, #4, and #5) agreed staff should have obtained a physician order when the resident changed from the mask to the nasal cannula.	F 281		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		4/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 309	Continued From page 25 care plan, and the residents' goals and preferences. (I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 2 of 2 sampled residents (Resident #10 and #12) identified with low blood glucose levels. Failure to notify the physician of the residents' low blood glucose levels, assess/reassess low blood glucose levels, provide interventions for low blood glucose levels, and failure to administer insulin per physician orders may result in adverse side effects related to low blood glucose levels and poorly controlled diabetes and does not allow the residents to maintain the highest practicable level of physical well-being. Findings include: Review of the facility policy titled "Blood Gluclose [sic] Monitoring" occurred on 03/08/17. This policy, dated November 2013, stated, "Resident's blood sugars will be monitored according to physician's orders. Times and parameters for these blood sugars should be ordered by the physician. Emergency interventions for low blood sugars may be initiated prior to calling the physician including offering food, especially carbohydrates and sugars. . . . A glucose check	F 309	F 309 1. Resident #10: The Charge Nurse may have judged residents symptoms of lightheadedness and twitching as mental status change for reason for glucagon administration. The physician order continues for Resident #10 to notify MD for symptomatic blood sugars below 50, order continues for administration of glucagon for BS below 50 with symptomatic mental changes of hypoglycemia. Nurses are to follow MD orders and document in progress notes if MD is notified. Resident #12: Res order continues notify physician if blood sugar below 60 or over 400. Nurses will document in MAR and progress notes if resident is out of facility and unavailable for blood sugar monitoring and insulin administration. Nurses are to follow MD orders as a standard of nursing practice. 2. All diabetic residents could be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26 may be done by the charge nurse if the resident's status indicates the blood sugar may be irregular. . . ." Review of the facility policy titled "Medication Administration" occurred on 03/08/17. This policy, dated October 1999, stated, "1. Medications must be administered in accordance with the written orders of the physician. . . . 14. Should a drug be withheld, refused or given other than at the scheduled time, the administrator of the drug must initial and circle the MAR [medication administration record] space provided for that drug. The administrator should also enter an explanatory note on the reverse of the MAR. . . ." - Review of Resident #10's medical record occurred on 03/08/17. Diagnoses included diabetes mellitus and dementia. Physician's orders included the following: * Glucose check four times a day at 3:00 a.m., 7:00 a.m., 11:00 a.m., 5:00 p.m. * Lantus (long acting insulin) 30 units at 7:00 a.m. * Humalog (short acting insulin) Flexpen 12 units at 7:30 a.m. and 11:45 a.m. * Humalog Flexpen 8 units at 5:00 p.m. * Humalog sliding scale (amount depends on the glucose reading) * Special instructions: Notify medical doctor of symptomatic low blood sugar or greater than 450 milligrams per deciliter (mg/dL) * A standing order stated, "S &S [signs and symptoms] of hyper/hypoglycemia [high or low blood sugar]: . . . Glucagon Inj. [injection] per pkg. [package] instructions for low blood sugars and notify MD [medical doctor]"	F 309	3. All diabetic residents will have MD notification when blood sugars are out of parameters indicated by MD order. These blood sugars will be documented in progress notes as well as interventions, MD notification and follow up. Residents that do not have insulin administered as ordered will have documentation in progress notes of reasons for non-administration ie, out of facility on activity outing. Policy for insulin administration and documentation will reflect the above POC. Charge Nurses will be educated on this policy and POC on April 6th at Charge Nurse meeting. 4. Nursing Management will audit 10 residents blood sugars for policy compliance after completion date; week x 4; then bi-weekly x2, then monthly x4. Findings will be reported to the QAPI Nurse, QAPI Committee at Quarterly QAPI Meetings. 5. Completion date April 13th.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 27	F 309		

Resident #10's current care plan stated, ". . . Resident has a diagnosis of diabetes that requires close monitoring and staff intervention due to her fluctuating values from day to day . . . Approach: If resident's blood sugar is below 50 [mg/dL] and change in mental status staff to administer glucagon as ordered. . . . Nutritional Status . . . has diagnosis of diabetes requiring nutritional monitoring. Goal: Will maintain and control s/s [signs and symptoms] related to current diagnosis . . ."

A progress note, dated 12/23/16 at 2:10 p.m. stated, "CN [charge nurse] was called by day CNA [certified nursing assistant]; res [resident] was sitting on toilet and suddenly became lightheaded and having 'twitching' movements in upper extremities; pale with slight diaphoresis [sweating]. BS [blood sugar] 37. Res was able to converse and hold a conversation; 2 pm [2:00 p.m.] yogurt offered and taken. Res was given one Glucagon injection into the abd [abdomen] fold; will retake BS shortly."

The medical record failed to show facility staff notified Resident #10's doctor related to a blood sugar of 37 mg/dL and failed to show a follow up assessment and a repeat of the blood glucose level until 4:45 p.m. (two and a half hours later). Even though Resident #10 could tolerate oral intervention, the staff administered Glucagon.

Review of Resident #10's blood sugar readings from 01/12/17 through 03/08/17 identified seven occasions her blood sugar measured between 42 and 50 mg/dL and 11 occasions her blood sugar measured between 50 and 60 mg/dL. Review of the resident's progress notes showed no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 28	F 309		

documentation (except for once on 01/12/17) of any signs and/or symptoms she may have experienced related to a low blood sugar level or interventions provided.

During an interview on 03/08/17 at 1:35 p.m., an administrative nurse (#3) stated she expected facility staff to document in the progress notes a low blood sugar reading and any interventions provided related to the low blood sugar.

- Review of Resident #12's medical record occurred on 03/08/17. Diagnoses included diabetes mellitus and dementia. The current care plan states, ". . . Nutritional Status . . . has a diagnosis of diabetes requiring nutritional monitoring . . . Will maintain and control s/s related to current diagnosis. . . ."

Review of the Physician Order Report, dated 02/08/17 through 03/08/17, identified the following
* Glucose check four times a day at 6:00 a.m., 11:00 a.m., 5:00 p.m., and 8:00 p.m.
* Novolog Flexpen 4 units before lunch, supper and bedtime. Call MD if blood sugar less than 60 mg/dL or greater than 400 mg/dL

Review of Resident #12's blood sugars from January 1 through March 7, 2017 identified on 7 occasions staff recorded blood sugars less than 60 mg/dL. Review of the resident's progress notes showed no documentation staff notified the physician of the resident's low blood sugars or interventions provided.

Review of Resident #12's February 2017 electronic medication administration record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 29 (eMAR) showed on 02/23/17 staff documented at 10:32 a.m. "Resident unavailable" for glucose monitoring and at 10:56 a.m. "Resident unavailable" for insulin (Novolog 4 units) administration. Staff documented at 5 p.m. a blood glucose of 268 mg/dL and Novolog 4 units administered. Review of the progress notes for 02/23/17 showed no documentation of why the resident had been unavailable for the glucose check and insulin administration, or if staff administered the dose late. During an interview on 03/08/17 at 3:50 p.m., an administrative staff member (#6) agreed staff failed to document why the resident had been unavailable for the glucose check and insulin administration, and upon further investigation stated the resident had been out of the facility at the time via the facility van. Staff failed to make any written documentation of the resident leaving the facility.	F 309		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or	F 329		4/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 30 (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to ensure a medication regimen free from unnecessary drugs for 8 of 11 sampled residents (Resident #1, #3, #4, #6, #7, #9, #11, and #12) who received as needed (PRN) pain and/or anxiety medications. Failure to monitor the effectiveness of the medication placed residents at risk of receiving unnecessary medications, experiencing adverse consequences related to their use, and ineffective pain and/or anxiety relief. Findings include:	F 329	F 329 1. Residents #□s 1,3,4,6,7,9,11 and 12 did not show harm or negative outcome from this deficient practice. POC written, policy for medication administration revised to include prn follow up time frame. 2. All residents receiving PRN medications have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

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F 329	Continued From page 31 Review of the facility policy titled "Medication Administration" occurred on 03/08/17. This policy, dated October 1999, stated, ". . . Document PRN medications in matrix: . . . the result of medication must be completed by the nurse. . . ." Review of the facility policy titled "Psychoactive Drugs/PRN Psychotropics/TD [tardive dysconesia] Testing" occurred on 03/08/17. This policy, dated January 2016, stated, ". . . When use of a prn psychotropic drug is used, the nurse will: . . . Response to the psychotropic drug in MAR [Medication Administration Record] PRN record and in nurses notes for each dose administered. . . ." - Review of Resident #1's medical record occurred on all days of survey. Diagnoses included right below the knee amputation, polyneuropathy, and chronic pain. Physician's orders included PRN acetaminophen 1000 milligram (mg) every six hours. Review of Resident #1's MARs for February 1-28, 2017 identified the following: * On 4 occasions staff administered PRN acetaminophen. On 4 of 4 occasions staff failed to assess the efficacy of the medication within one hour. The follow-up times ranged from 1.25 hour to 8.25 hours. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included knee pain and osteoarthritis. Physician orders included PRN ibuprofen 400 mg three times a day.	F 329	3. PRN medication policy will be revised stating PRN medications administered will be followed up by charge nurse within one hour after administration. Charge nurses will be educated on this policy and POC at the Charge Nurse Meeting on 4/06/17. 4. Nursing Management will audit 10 residents receiving PRN medications for timely follow up and policy compliance after completion date: weekly x4, bi-weekly x2, and monthly x4. Findings will be reported to QAPI Nurse QAPI Committee at Quarterly QAPI Meetings. 5. Completion date 4/13/17.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32 Review of Resident #3's MARs for February 1 through March 7, 2017 identified the following: * On 5 occasions staff administered PRN ibuprofen. On 2 occasions staff failed to assess the efficacy of the medication within one hour and on 3 occasions staff failed to document the follow-up time. The follow-up times ranged from 2 to 7 hours. - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included left bunion surgery (02/02/17) and osteoarthritis. Physician orders included oxycodone-acetaminophen 5-325 mg every four hours PRN for pain. Review of Resident #4's MARs for February 1 through March 7, 2017 identified the following: * On 39 occasions staff administered PRN oxycodone-acetaminophen. On 26 occasions staff failed to assess the efficacy of the medication within one hour and on 11 occasions staff failed to document the follow-up time. The follow-up times ranged from 2.5 to 8 or more hours. - Review of Resident #6's medical record occurred on all days of survey. Diagnoses included pain in right knee and osteoarthritis, right knee. Physician orders included morphine solution 5 mg equals 0.25 milliters sublingual every 1 hour PRN for pain or air hunger and Tylenol 650 mg PRN every 4 hours. Review of Resident #6's MARs for February 1 through March 7, 2017 identified the following: * On 3 occasions staff administered PRN	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33	F 329		

morphine and each time failed to assess the efficacy of the medication within one hour. The follow-up times ranged from 5.5 to 7.5 hours.
* On 6 occasions staff administered PRN Tylenol and each time failed to assess the efficacy of the medication within one hour. The follow-up times ranged from 3.5 to 11 hours.

- Review of Resident #7's medical record occurred on all days of survey. Diagnoses included bilateral shoulder pain. Physician orders included hydrocodone/acetaminophen 5-325 mg every 6 hours and acetaminophen 650 mg every 4 hours PRN.

Review of Resident #7's MARs, dated February 1 through March 7, 2017, identified the following:
* On 02/01/17, facility staff administered PRN acetaminophen at 1:07 p.m. for pain. The MAR showed staff completed a follow-up pain assessment at 10:30 p.m., approximately 9 hours after administration of the acetaminophen.
* On 02/07/17, facility staff administered PRN acetaminophen at 8:13 p.m. for pain. The record failed to show staff monitored the effectiveness of the pain medication.

- Review of Resident #9's medical record occurred on 03/08/17. Diagnoses included dementia, depression, and anxiety. Physicians orders included alprazolam (antianxiety medication) 0.25 mg PRN and 0.5 mg one time a day PRN.

Review of Resident #9's MARs for February 1 through March 7, 2017 identified the following:
* On 7 occasions staff administered PRN alprazolam. On 2 occasions staff failed to assess

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 34	F 329		

the efficacy of the medication within one hour and on 2 occasions staff failed to document the follow-up time. The documented follow-up times ranged from 8 or more hours.

- Review of Resident #11's medical record occurred on all days of survey. Diagnoses included bilateral osteoarthritis of hip, pain in left and right hip, and anxiety. Physician orders included hydrocodone-acetaminophen tablet 7.5-325 mg PRN every 4 hours for pain and lorazepam 0.5 mg PRN every 6 hours for agitation/anxiety.

Review of Resident #11's MARs for February 1 though March 7, 2017 identified the following:
* On 20 occasions staff administered PRN hydrocodone-acetaminophen. On 15 occasions staff failed to assess the efficacy of the medication within one hour. The follow-up times ranged from 2 to 20 hours.
* On 2 occasions staff administered PRN lorazepam and failed to follow-up in a timely manner. The follow-up times ranged from 2 to 6 hours.

- Review of Resident #12's medical record occurred on 03/08/17. Diagnoses included low back pain. Physician orders included Tylenol Extra Strength 1000 mg PRN every day. The current care plan stated, ". . . Pain . . . Administer medication . . . Monitor and record effectiveness. . . ."

Review of Resident #12's MARs for February 1 through March 7, 2017 identified the following:
* On 2 occasions staff administered PRN Tylenol Extra Strength and failed to follow-up within one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 35 hour. The follow-up times ranged from no follow-up to 6 hours. During an interview on 03/07/17 at 3:45 p.m., a supervisory nurse (#4) stated she expected staff to follow-up on PRN pain medications one hour after administration of the medication.	F 329		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to ensure a medication error rate of less than five percent during 2 of 4 residents observed (Resident #9 and #10) receiving insulin during medication pass. Two medication errors occurred during staff administration of 35 medications, resulting in a 5% error rate. Failure to ensure staff administered insulin at the correct time may result in adverse side effects such as hypoglycemia (low blood glucose). Findings include: The "Nursing 2015 Drug Handbook," 35th Edition, Wolters Kluwer, Pennsylvania, page 756-757, stated, "Humalog . . . Inject subcutaneously within 15 minutes before or after a meal. . . ." Page 759, stated, ". . . Novolog . . . Give 5 to 10 minutes before start of meal . . ."	F 332	F 332 1. Resident #9 and 10 did not have a negative outcome due to this deficient practice. Nurse #1 was instructed by management nursing to administer Humalog and Novolog insulins per these insulins package insert protocol. 2. All residents receiving Humalog and Novolog insulins could be affected by this deficient practice. 3. Charge nurses will be educated on insulin administration at the charge nurse meeting on April 6th to administer insulin as per package insert directions. Humalog 15 minutes before or after meal consumption and Novolog 5 to 10 minutes before the start of a meal.	4/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355092	A. BUILDING _____ B. WING _____	03/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILL TOP HOME OF COMFORT INC	95 HILL TOP DR KILLDEER, ND 58640

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 36 - Observation on 03/07/17 at 7:00 a.m. showed the nurse (#1) administered 12 units of Humalog to Resident #10. The resident had nothing to eat or drink until her morning meal arrived at 7:57 a.m., 57 minutes after receiving Humalog. - Observation on 03/07/17 at 7:06 a.m. showed the nurse (#1) administered 6 units of Novolog to Resident #9. The resident had nothing to eat or drink until her morning meal arrived at 8:01 a.m., 55 minutes after receiving Novolog. The above errors resulted in a 5% medication error rate. Additional observations on 03/07/17 showed the following: * At 10:25 a.m. - The nurse (#1) administered 4 units of Novolog, scheduled for 12:00 p.m., to Resident #9. The resident had nothing to eat or drink until her noon meal at 11:55 a.m., 90 minutes after receiving Novolog. * At 10:45 a.m. - The nurse (#1) administered 12 units of Humalog, scheduled for 11:45 a.m., to Resident #10. The resident had nothing to eat or drink until her noon meal at 11:48 a.m., 63 minutes after receiving Humalog. During an interview on 03/07/17 at 2:30 p.m., two administrative nurses (#3 and #4) stated they expected nursing staff to administer insulin (Novolog and Humalog) right before the residents received their meal.	F 332	4. Nursing Management will audit 10 residents receiving Novolog or Humalog insulins for appropriate administration time after completion date: weekly x4, bi-weekly x2, monthly x4. Findings will be reported to the QAPI Nurse and the QAPI committee at Quarterly QAPI meetings. 5. Completion date 4/13/17.	