| 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 _____ | 05/10/2018 |

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

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| F 000 | INITIAL COMMENTS<br><br>The standard Medicare/Medicaid recertification survey started on 05/07/18 and concluded on 05/10/18. | F 000 | | |
| F 567 SS=E | Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii)<br><br>§483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.<br>(i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.<br>(ii) Deposit of Funds.<br>(A) In general: Except as set out in paragraph (f)( l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.<br>(B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any | F 567 | | 6/14/18 |

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

Electronically Signed | 05/22/2018

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| F 567 | Continued From page 1<br>of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by:<br>Based on resident and staff interview, the facility failed to have a system in place to assure 2 of 2 residents (Resident A and B) had ready access to personnel funds on the weekend. Failure to provide residents access to their personnel funds on the weekend may limit resident's rights to their money.<br><br>Findings include:<br><br>During a resident interview on 05/07/18 at 2:53 p.m., when asked about obtaining money from the resident's personal fund account, Resident A stated, "Not sure if I can get money on the weekends."<br><br>During a resident interview on 05/07/18 at 4:07 p.m., when asked about obtaining money from the resident's personnel fund account, Resident B stated, "The money is not available on weekends."<br><br>During an interview on 05/08/18 at 3:52 p.m., an administrative office staff member (#1) confirmed residents cannot get money on the weekends as the office is closed. | F 567 | F567<br><br>1. All resident□s and/or their family members will be given written notice specifying resident personal funds are available on weekends and after business hours.<br><br>2. All Residents with personal resident trust funds set up through Hill Top have the potential to be affected by this deficient practice.<br><br>3. The facility will notify the resident and/or family members that resident personal trust funds are available for petty cash during non-business hours. Resident personal trust policy will be implemented and educated at the Charge nurse meeting on 06/07/2018 and reviewed with office staff on 06/07/2018. The Petty cash will be kept locked at nurses station. Nurse will fill out Petty cash form and have resident sign to withdraw monies from personal resident trust funds. Petty cash form will be turned into business office.<br><br>4. The business office will audit the | |

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| F 567 | Continued From page 2 | F 567 | availability of money locked in med room at unit 2 to ensure money is available after business hours weekly x4, bi-weekly x2, then monthly x4. Findings will be reported to QAPI nurse, QAPI Committee and at the Quarterly QAPI meeting.<br><br>5. Completion Date 06-14-2018 | |
| F 644 SS=D | Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASRR) and Level of Care Screening Procedures For Long Term Care Services, and staff interview, the | F 644 | F 644<br><br>1. A new PASRR screening will be completed for resident # 3 with all her current diagnosis included. | 6/14/18 |

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| F 644 | Continued From page 3<br>facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #3) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with residents' needs.<br><br>Findings include:<br><br>The North Dakota PASRR Provider Manual page 13 states, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ."<br><br>Review of Resident #3's medical record occurred on all days of survey. The record showed an initial PASRR completed on 05/18/15 and identified no mental illness. The screening, dated 05/18/15, stated, ". . . Based on the information received, she will be given a No Level 2 Conditions/Level 1 Negative approval due to no MMI [major mental illness], no ID [intellectual disability] or related condition diagnosis. Should there be an exacerbation related to mental illness, a status change should be submitted to Ascend for further evaluation." | F 644 | 2. All residents who receives new mental disorder diagnosis after most recent PASRR have the potential to be affected by this deficient practice.<br><br>3. The social services designee(SSD) or nurse management will review all current residents most recent PASRR and those who received a new diagnosis of mental disorder after the most recent PASRR and will have a new PASRR completed if indicated. SSD will complete and submit any indicated PASRR by June 14, 2018. New mental disorder diagnosis will be tracked by SSD and/or Nursing Management. Nurses, social services designee and medical records will be educated on informing SSD or nursing management when a new diagnosis is received at the nurses meeting at June 7, 2018.<br><br>4. A Tracking form will be initiated by QAPI nurse and SSD will keep it ongoing for any resident that receives a new mental disorder diagnosis. All current residents will have diagnosis review and new PASRR completed if indicated by June 14, 2018. New admissions after 5/25/18 and 10% of current residents will have mental health diagnosis review in 2nd month, 10% of residents will have mental health diagnosis review 3rd , 4th, 5th and 6th months. The initial reviews will include all the current resident population. | |

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| F 644 | Continued From page 4<br><br>Review of Resident #3's medical record identified current diagnoses of unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, psychotic disorder with hallucinations and anxiety disorder. The record lacked evidence of an updated Level I screening/change in status assessment since the additional diagnoses.<br><br>During an interview in afternoon of 05/09/18, an administrative nurse (#2) confirmed the facility failed to submit a PASRR for Resident #3 with the change in status. | F 644 | 5. June 14th, 2018. | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, review of facility policy, and staff interview, the facility failed to implement interventions to prevent skin breakdown for 1 of 1 sampled resident (Resident #2) utilizing a wheelchair and at risk for pressure | F 686 | F 686<br><br>1. Res #2 had a pressure relief cushion placed on her w/c as identified per CP and Braden Scale Risk Assessment. | 6/14/18 |

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| F 686 | Continued From page 5<br>ulcers. Failure to consistently use interventions for pressure relief (i.e. pressure relief wheelchair cushion) may result in skin breakdown.<br><br>Findings include:<br><br>Review of the facility policy titled "SKIN ASSESSMENT AND PRESSURE ULCER RISK ASSESSMENT" occurred on 05/10/18. This undated policy, stated, ". . . All Residents have skin assessment on admission, with interventions if needed and CP [care plan] initiated for preventions of skin breakdown. . . ."<br><br>Review of Resident #2's medical record occurred on all days of survey. A quarterly Minimum Data Set, dated 02/01/18, identified Resident #2 required extensive assistance of one person for transfers and bed mobility, frequently incontinent of bowel and bladder, and at risk for pressure ulcers. Review of the "Braden Scale for Predicting Pressure Sore Risk," dated 11/02/17, showed a score of 17 indicating a risk for skin breakdown.<br><br>Resident #2's current care plan stated, ". . . I need assistance with my activities of daily living. I am at risk of developing complications associated with decreased ADL [activities of daily living] self-performance Related to Dx [diagnosis], Disease Process, & [and] debility. Please provide the following devices Walker, Wheelchair, Pressure Relief Cushion, Pressure Relief Mattress . . . Problem . . . Urinary Incontinence, I am frequently incontinent of bladder and bowel. I have a potential for complications associated with urinary incontinence, Skin breakdown . . ." | F 686 | 2. All residents with risk for skin breakdown requiring a pressure reducing cushion could be affected by this deficient practice.<br><br>3. All residents with need for a pressure relief will have this identified in their Care Plan. Residents that require a pressure relief cushion in their w/c will have a red sticker placed on their w/c for quick identification. If a pressure reducing cushion is missing it will be reported to Charge Nurse or Nursing Management and action will be taken to replace the cushion. Nursing and CNA□s will be educated on following CP and new intervention for marking w/c on Nursing/CNA meeting on 06/07/2018.<br><br>4. RT CNA and QAPI/IC nurse will audit 12 residents requiring pressure reducing cushions q week x 4 weeks; then 12 residents q 2 weeks x one month; then monthly x 4 months.<br><br>5. June 14th, 2018. | |

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| F 686 | Continued From page 6<br><br>Observations on 05/08/18 at 7:53 a.m. and 05/09/18 at 10:42 a.m. showed Resident #2 sitting in her wheelchair without a pressure relief cushion.<br><br>During an interview on 05/10/18 at 8:05 a.m., an administrative nurse (#2) confirmed Resident #2 should have a cushion in her wheelchair. | F 686 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #33) remained capable of safely using an electric wheelchair based on a comprehensive assessment. Failure to reassess Resident #33's ability to utilize an electric wheelchair may result in injury to residents, staff, and visitors.<br><br>Findings include:<br><br>Review of Resident #33's medical record occurred on all days of survey. The current care plan stated, " . . . I need assistance with activities of daily living. . . . Wheelchair manual and electric per res [resident] choice . . ." | F 689 | F 689<br>1. An order was received on 05/22/2018 from PCP for electric W/C evaluation for Res #33 and it is scheduled to be completed on 5/24/2018 to determine his abilities/safety of continued use of electric w/c. The evaluation is scheduled an upon completion Skilled therapy recommendations will be followed according to the evaluation.<br><br>2. All residents with use of electric w/c□s have the potential to be affected by this deficient practice.<br><br>3. A policy will be implemented for all | 6/14/18 |

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| F 689 | Continued From page 7<br><br>Observation on all days of survey showed Resident #33 utilized an electric wheelchair for mobility in the facility.<br><br>Review of nursing progress notes identified the following:<br>* 05/01/18 at 1:03 p.m. "Resident was up in electric wheel chair before lunch and fell asleep in lounge with w/c [wheelchair] on, hand hit button and started to go around in a circle, staff able to turn off chair before any one was hurt. . . . Explained to resident that staff is only concern [sic] about resident and another resident being safe and that no one is hurt. . . ."<br>* 01/29/18 at 6:52 p.m. "Resident up in electric wheel chair going in to another's [sic] resident room . . . Resident also ran into the wall by shower room door, he looked around to see if anyone saw it and cont [continued] on done [sic] the hall. . . . Resident was having a hard time staying a wake."<br>* 01/09/18 at 5:01 p.m. "Care conference held today with [Resident #33] and his brother [name]. Discussion held in regards to [Resident #33] and safety with his electric wheelchair. [Resident #33] has [sic] found sleeping in his electric wheelchair often lately. Educated that he and all other residents need to be kept safe. . . ."<br>* 12/26/17 at 11:48 a.m. SSD [Social Service Designee] found res [resident] in Badlands Lounge sleeping in his electric wheelchair. Awoke res and visited with him in regards to his wheelchair. Explained to res the importance of operating his electric wheelchair safely. Educated that it is not safe to sleep in wheelchair and that if he can't operate it safely he will not be able to use. . . ." | F 689 | residents who request to use an electric wheel chair or scooters stating the following practices: All residents wishing to have use of electric motorized chair or scooter will have an initial skilled therapy evaluation for safety before use. All residents with use of these motorized chairs will have an annual evaluation by skilled therapy for ongoing safety and use. Any safety concerns noted by any staff will be reported to Nursing Management or Charge Nurse by making out an incident report. Further skilled evaluation will be determined by assessment and investigation of incident report by Nursing Management.<br>All staff will be educated on completing incident reports for electric w/c safety concerns/incidents; at CNA/ Charge Nurse Meeting on 6/7/2018; all other staff per individual Education Safety Memo and form to be used.<br><br>4. Audits will be done by nurse managers on each resident that currently uses an electric W/C and any new resident with an electric w/c to ensure a skilled therapy evaluation in past year has been done in first month.; then monthly x<br>5. Nurse management team will evaluate and assess all w/c incident reports to ensure proper investigation, initiate any interventions necessary and follow through of skilled therapy evaluation if recommended. Skilled therapy assessment for safety and proper use of electric W/C will be completed on all residents using electric W/C annually and | |

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| F 689 | Continued From page 8<br>* 12/26/17 at 11:26 a.m. "Resident reported to nurse that while his (sic) was in his room in electric wheelchair he drove his foot into the wall, left foot middle medial toe has skin tear approx. [approximately] 1 cm [centimeter] long, area cleansed with pressure dressing applied . . ."<br>* 12/24/17 at 8:00 a.m. Res. was sitting in his electric w/c at the dining room table for bkfst [breakfast]. He fell asleep, accidentally hitting the joy stick w [with] /his hand on the w/c. The w/c then spun around in HIGH gear, (nearly missing res. [medical record number] who was standing several feet away) and became lodged under the table. [Resident #33], at this point, awoke and was instructed to turn the w/c "OFF" for every meal. . . .<br><br>During an interview on the afternoon of 05/09/18, an administrative nurse (#2) stated staff completed Resident #33's electric wheelchair assessment in 2016. Later the same afternoon an administrative nurse (#3) identified in January 2018 Resident #33 had a decline in his condition, they removed his electric wheelchair however failed to complete an assessment when they returned the electric wheelchair to him. | F 689 | with any significant change in status or concerns of safety reported to nurse managers. All incident reports and outcomes will be audited and collected by QAPI nurse. Results of audits will be evaluated at quarterly QAPI meeting.<br><br>5. June 14th, 2018. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control | F 880 | | 6/14/18 |

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| F 880 | Continued From page 9<br>program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable | F 880 | | |

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| F 880 | Continued From page 10<br>disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 2 of 8 sampled residents (Resident #29 and #44) observed during perineal cares. Failure to practice infection control related to hand hygiene has the potential for transmission of infections throughout the facility.<br><br>Findings include:<br><br>Review of the facility policy titled "Hand Hygiene" occurred on 05/10/18. This policy, dated August 2017, stated, "Staff involved in direct resident contact will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. . . 3. Hand hygiene is indicated and will be performed under | F 880 | F 880<br><br>1. Res #44 and res #29 will be protected from the transmission of communicable diseases and infections by staff following Hill Top Homes policy for Hand Hygiene.<br><br>2. All residents have the potential to be affected by this deficient practice.<br><br>3. CNA□s will be educated on HTH policy for hand hygiene including hand hygiene after peri cares on CNA/Nursing Meeting on June 7, 2018. All staff will be educated at least annually on hand hygiene practices.<br><br>4. Nurse Managers will complete hand | |

| 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 _____ | 05/10/2018 |

| 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 880 | Continued From page 11<br>conditions listed in . . . hand hygiene table . . . Before applying and after removing personal protective equipment (PPE), including gloves . . . After assisting with personal body functions. . . ."<br><br>Observation on 05/08/18 at 8:25 a.m. showed a certified nursing assistant (CNA) (#4) assisted Resident #44 off the toilet and provided perineal care after a small bowel movement (BM). The CNA (#4) removed her gloves and assisted the resident into bed using the sit to stand lift. Without performing hand hygiene, the CNA (#4) removed the resident's shoes, adjusted the blankets, gave the resident a drink of water and her call light. The CNA (#4) failed to perform hand hygiene after ensuring the resident's safety prior to completing other tasks.<br><br>Observation on 05/08/18 at 8:44 a.m. showed a CNA (#4) assisted Resident #29 off the toilet. The CNA (#4) provided perineal care after a small BM, removed her gloves and assisted Resident #29 into bed. Without performing hand hygiene, the CNA adjusted Resident #29's pillows and blankets, gave the resident a drink of water, and his call light. The CNA (#4) failed to perform hand hygiene after ensuring the resident's safety prior to completing other tasks.<br><br>During a interview on 05/10/18 at 8:30 a.m., an administrative nurse (#2) stated after completing perineal care she expected staff to remove gloves, ensure the resident's safety, then perform hand hygiene before doing other tasks. | F 880 | hygiene audits will be done during direct care of residents on 10 staff weekly x 4 weeks; then 10 staff q 2 weeks x 2; then 10 staff q month x 4 months. All department staff will continue to be educated at least annually on hand hygiene practices. Audits will be reported and evaluated to QAPI Nurse Manager. Hand hygiene audit goal to maintain 90% or greater compliance. Results of audits will be evaluated at quarterly QAPI meeting.<br><br>5. June 14th, 2018 | |