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 _____	06/23/2022

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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 06/20/22 and concluded on 06/23/22.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		7/28/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/14/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure a safe, clean, comfortable, homelike environment on 3 of 4 units (Meadow Lane, Northern, and Spring). Failure to maintain a safe, clean, and sanitary environment does not provide a comfortable/homelike environment and places residents at risk for injury. Findings include: Observations of the environment on all days of the survey showed the following: - Meadow Lane Rooms 1101 - personal fan soiled with dust and heat register with broken piece hanging off the register 1103 - wall near the bed with scuffed/scraped areas 1104 - wall near the bed with scuffed/scraped areas 1106 - wall in the bathroom with scuffed/scraped areas 1109 - wall in the bathroom with two areas of missing paint 1110 - wall near the bed with scuffed/scraped areas and an open cable TV outlet box with exposed cable cords 1111 - two open cable TV outlet boxes with exposed cable cords	F 584	1. On 7/14/2022 the Maintenance department fixed all areas of concern on Meadow, Northern and Spring. 2. All resident rooms have the potential to be affected by this practice. 3. A Maintenance Monthly Inspection Checklist has been created. The Maintenance Supervisor will conduct monthly inspections of all rooms and hallways to identify and address any needed repairs or painting to walls, cleaning of personal fans, outlet boxes with exposed cable cords or broken pieces on registers. The monthly inspection checklists will be turned into the Administrator for 6 months to ensure inspections are being completed. By 7/25/2022 Each Department Manager will educate their department staff how to report any identified repairs, painting or cleaning to the maintenance supervisor upon observation by filling out a maintenance slip. 4. Nurse Management will conduct audits on 5 resident rooms weekly x 4	

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F 584	Continued From page 2 1112 - an open cable TV outlet box with exposed cable cords - Northern Rooms 1201 - wall behind the bed scuffed/scraped 1202 - wall behind the bed scuffed and scraped 1205 - broken outlet on the wall and some of the heat register pieces broken 1206 - wall behind the bed scuffed/scraped, holes in wall where previous items hung, open cable TV box with exposed cable cords, heat register smashed in at the end, and wall under window with dark dirty spots 1211 - wall behind the bed scuffed/scraped. - Spring Rooms 1403 - scratches in the paint on 3 of the walls. 1404 - scrapes and gouges in the wall behind the bed and recliner, and patched unpainted areas under the TV 1405 - large patched, unpainted area by the bathroom 1406 - large gouges in the wall by the video game table 1407 - gouges behind the head of bed 1408 - patched unpainted area behind the bathroom door 1409 - multiple scrapes on the wall and gouges beneath the TV mount A wall at the end of Spring unit's hallway with gouged, scuffed/scraped areas, a wooden box in the hallway with computer hookup wires from old electronic health system During an environmental tour on 06/23/22 at 8:20 a.m., an administrative staff (#1) stated he expected nursing staff to submit work orders and maintenance staff to cover the cable TV outlets.	F 584	weeks; then 5 resident rooms every 2 weeks x 2 months; then 5 resident rooms every month x 3 months. Results will be reviewed by the QAPI nurse and Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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: INSULIN ADMINISTRATION 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #40) and two supplemental residents (Residents #18 and #36) observed receiving insulin. Failure to administer insulin as instructed may result in residents receiving an inaccurate dose of insulin. Findings include: Review of the facility policy titled "Insulin Pen" occurred on 06/22/22. This policy, revised 10/2021, stated, ". . . Injecting the insulin: . . . While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin. . . ." Observation of insulin administration showed the following: * 06/22/22 at 9:30 a.m., a staff nurse (#4) administered 3 units of insulin via pen to Resident #18. After injecting the insulin, the staff nurse (#4) failed to keep the needle in the skin for 6-10 seconds. * 06/22/22 at 11:27 a.m., a staff nurse (#4) administered 2 units of insulin via pen to	F 658	1. For Insulin Administration: All nursing staff have been educated on the facilities insulin policy to keep needle in the skin for 6-10 seconds. For Transcribing Orders: Resident #37 order now reflects the resident's current order of Mechanically altered NDD3 diet. 2. The facility has determined that all residents have the potential to be affected 3. On 7/25/2022 a Nurses meeting will be held by the Nurse Management team to provide in-service education for nursing staff regarding the transcription and submission of physician orders and insulin administration as per policy. 4. Nurse Management will conduct audits on 5 resident diet orders weekly x 4 weeks; then 5 resident diet orders every 2 weeks x 2 months; then 5 resident diet orders every month x 3 months. Nurse Management will conduct audits on 5 insulin injections weekly x 4 weeks; then 5 resident insulin injections every 2 weeks x 2 months; then 5 resident insulin	7/28/22

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F 658	Continued From page 4 Resident #40. After injecting the insulin, the staff nurse (#4) failed to keep the needle in the skin for 6-10 seconds. * 06/22/22 at 11:37 a.m., a staff nurse (#4) administered 10 units of insulin via pen to Resident #36. After injecting the insulin, the staff nurse (#4) failed to keep the needle in the skin for 6-10 seconds. During an interview on 06/23/22 at 9:07 a.m., two administrative nurses (#2 and #3) confirmed they expected staff to follow the facility policy regarding insulin administration. TRANSCRIBING ORDERS 2. Based on record review, review of facility policy, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sample resident (Resident #37) reviewed with a dietary order change. Failure to transcribe Resident #37's dietary order when received placed the resident at risk for adverse consequences. Findings include: Review of the facility policy titled "Medication Orders" occurred on 06/23/22. This policy, revised 09/20/21, stated, ". . .Verbal orders should be received only by licensed nurses, and confirmed in writing by the physician, on the next visit to the facility. . . All medication orders are documented into Matrix Care [electronic health record system] under current orders. . ." Review of Resident #37's medical record occurred all days of survey. The record showed a	F 658	injections every month x 3 months. Results will be reviewed by the QAPI nurse and Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 658	Continued From page 5 physician's order, dated 11/18/21, for a regular diet. A progress note, dated 12/09/21, stated, "Received telephone order from speech therapist stating, "NDD3 [National Dysphagia Diet] diet with all foods cut into small pieces, gravy/sauce added to meat, thin liquids ok via cup/straw, line of sight supervision, [sit at] 90 degree for all meals." The resident's current care plan identified a mechanically altered NDD3 diet matching the progress note documented on 12/09/21. During an interview on 06/23/22 at 8:39 a.m., two administrative nurses (#2 and #3) confirmed staff failed to transcribe Resident #37's dietary order into the medical record. Failure to transcribe the order at the time received has the potential for a negative consequence to the resident.	F 658		